Medicaid Enterprise
Department of Human Services

For Human Services use only:

General Letter No. 8-AP-291
Employees' Manual, Title 8
Medicaid Appendix

November 21, 2008

PRESCRIBED DRUGS MANUAL TRANSMITTAL NO. 08-2

ISSUED BY: Division of Medical Services, Iowa Department of Human Services

SUBJECT: ***PRESCRIBED DRUGS***, Table of Contents, new; Chapter III, *Provider-Specific Policies*, Contents (pages 1, 2, and 3), revised; pages 7 through 10, 12 through 32, 32a, 32b, 32c, 38 through 41, 54 through 66, revised; pages 32d and 67 through 79, new; and the following forms:

470-4093	*Request for Prior Authorization: Anti-Acne Products – Topical*, revised
470-4410	*Request for Prior Authorization: Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin Product*, revised
470-4522	*Request for Prior Authorization: Biologicals for Arthritis, revised*
470-4550	*Request for Prior Authorization: Extended Release Formulation*, new
470-4102	*Request for Prior Authorization: Ketorolac Tromethamine (Toradol®)*, revised
470-4109	*Request for Prior Authorization: Nonsteroidal Anti-Inflammatory Drugs*, revised
470-4409	*Request for Prior Authorization: Oxycodone CR/ER (Oxycontin®)*, revised
470-4551	*Request for Prior Authorization: Pregabalin (Lyrica®)*, new
470-4113	*Request for Prior Authorization: Serotonin 5-HT1 Receptor Agonists*, revised

Summary

Additions to the manual include:

- New forms and policies for requesting drug prior authorization.
- More information about edits in the point-of-sale system that can cause claims to be denied, such as age edits, refills too soon, plan limits exceeded, high-dollar claims, high-dose claims, and quantity limits.

Revisions to the manual include

- Updated forms for requesting drug prior authorization. Form 470-4277, *Request for Prior Authorization: Tiotropium Bromide (Spiriva®)*, is removed, since prior authorization is no longer required.
- Updated claim form instructions.
- An expanded list of common billing errors.

Date Effective

July 28, 2008

Material Superseded

Remove the following pages from Chapter III of the ***Prescribed Drugs Manual*** and destroy them:

Page	Date
Contents (pages 1 and 2)	May 1, 2008
Contents (page 3)	July 1, 2007
7, 8	January 1, 2006
9, 10	July 1, 2006
11	January 1, 2006
12-32, 32a, 32b, 32c	May 1, 2008
33-38	July 1, 2007
39-41	May 1, 2008
470-4093	5/08
470-4410	5/08
470-4522	5/08
470-4102	5/07
470-4109	5/08
470-4409	5/07
470-4113	10/07
470-4277	10/05
42-66	July 1, 2007

For those filing paper manuals, form samples should be removed from Chapter III of the ***Prescribed Drugs Manual*** and destroyed. *Request for Prior Authorization* samples should be filed in alphabetical order by title following page 40.

Additional Information

The new provider manual can be found at:

www.ime.state.ia.us/providers

If you do not have Internet access, you may request a paper copy of this manual transmittal by sending a written request to:

Iowa Medicaid Enterprise
Provider Services
PO Box 36450
Des Moines, IA 50315

Include your Medicaid provider number, name, address, provider type, and the transmittal number that you are requesting.

If any portion of this manual is not clear, please direct your inquiries to the Iowa Medicaid Enterprise Provider Services Unit.

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b. Dispensing Requirements

Pharmacists are required to:

- Dispense drugs in accordance with cost and quantity requirements established by state law.
- Dispense the **least costly item** in stock that meets the order of the doctor or other practitioner, as shown on the prescription.

c. Reason for Denial

The pharmacist should explain the reason for any **denial** of a requested drug or item to the member or caregiver. For example, denial could be due to one of the following:

- **Noncovered drug or item**. Explain why the drug or item is not covered and suggest alternatives to the member, caregiver, or practitioner.
- **Prior authorization requirement**. Explain the prior authorization process and requirements to the member or caregiver.

  When a patient presents a prescription for nonpreferred drug at a pharmacy and it is denied, contact the prescriber and ask if the prescriber wishes to choose a preferred drug.

  - If the prescriber wished to change to a preferred drug, the prescriber may dictate the new prescription order.
  - If the prescriber maintains that the nonpreferred drug is medically necessary, the prescriber is responsible for obtaining prior authorization.
- **Refill too soon**. Inform the member or caregiver of an approximate date the prescription can be refilled (generally, after 85% of the previous supply is used for controlled substances, carisoprodol-containing products, and tramadol-containing products, and after 75% of the previous supply is used for all other medications).

  If there are special circumstances, such as a change in dose, travel, or lost, stolen or destroyed medication, that result in an early refill, contact the IME Pharmacy Point of Sale (POS) Unit at (515) 725-1107 (local calls) or 877-463-7671 with the information. This information will be reviewed to determine if an override can be given to allow payment.

- **Plan limits exceeded**. Reference the limits list posted on the web site, www.iowamedicaidpdl.com, under "Quantity Limits." The dose should be consolidated to meet the quantity limits requirements.

  If there are special circumstances where adherence to the quantity limits is not possible, the prescriber should complete the Quantity Limit Override form and fax it to 1-800-574-2515. The clinical staff will review the information submitted and determine if an override can be given to allow payment.

If the member or caregiver is not satisfied with the explanation of the reason for a denial, refer the person to the member's DHS worker for assistance in filing an appeal or requesting an exception to policy. Appeal and exception requests may be filed on line through the following web site: http://www.dhs.state.ia.us/dhs2005/appeals.

d. Patient Counseling

Pharmacists must offer to discuss with each Medicaid member or the member's caregiver presenting a prescription those matters that, in the pharmacist's professional judgment, will enhance or optimize drug therapy. Appropriate elements of patient counseling may include:

- The name and description of the drug
- The dosage form, dose, route of administration, and duration of therapy
- The intended use of the drug, if known and expected action
- Special directions and precautions for preparation, administration, and use by the patient
- Common severe side or adverse effects or interactions and therapeutic contraindications that may be encountered, including their avoidance and the action required if they occur
- Techniques for self-monitoring drug therapy
- Proper storage
- Prescription refill information, including the approximate date the prescription can be refilled (generally, after 3/4 of the prescription is used)
- Actions to be taken in the event of a missed dose
- Comments relevant to the patient's drug therapy, including any other information peculiar to the specific patient or drug

Patient counseling is required in accordance with federal law at 42 USC Section 1396r-(g)(2)(A)(ii)(l) and state rules at 657 Iowa Administrative Code 8.20(1)-(2).

5. Drug Use Review

The drug use review (DUR) process was established to fulfill a federal requirement established by the federal Omnibus Budget Reconciliation Act of 1990. Iowa Medicaid has implemented both of the required DUR types:

- **Prospective drug utilization review** occurs when the pharmacist does the review of patient drug therapy at the point of sale. See Pharmacist Responsibilities.
- **Retrospective drug utilization review** occurs when the review takes place after the point of sale.

The retrospective DUR program provides ongoing periodic examination of claims data and other records in order to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care among physicians, pharmacists, and members, or associated with specific drugs or groups of drugs.

B. COVERAGE OF SERVICES

Payment will be made for legend and nonprescription drugs when prescribed by a practitioner that is legally qualified to prescribe the item, subject to the limitations described in this manual.

1. Drugs Excluded From Coverage

Medicaid payment will **not** be made for:

- Drugs used to cause anorexia, weight gain or weight loss. (EXCEPTION: Payment will be made for lipase inhibitor drugs for weight loss with prior authorization.)
- Drugs used for cosmetic purposes or hair growth.
- Drugs used to promote smoking cessation. (EXCEPTION: Payment will be made for generic bupropion sustained-release products that are FDA-indicated for smoking cessation, varenicline (Chantix™) with prior authorization, and for nonprescription nicotine patch and gum with prior authorization.)
- Drugs used for fertility purposes or for male sexual enhancement.
- Drugs prescribed for a use other than the drug's medically accepted use.

- Drugs classified as less than effective by the Centers for Medicare and Medicaid Services.
- Drugs marketed by manufacturers that have not signed a Medicaid rebate agreement.
- Covered outpatient drugs for which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or the manufacturer's designee.

2. Prescription Requirements

Prescription records are required for all drugs as specified in Iowa pharmacy and drug laws (including Iowa Code sections 124.308, 155A.27, and 155A.29).

For Medicaid purposes, prescriptions are required for nonprescription drugs and are subject to the same provisions. This includes the record-keeping requirements on refills. Maintain prescriptions on file in such a manner that they will be readily available for audit by the Department.

Prescription drugs for which the prescription was executed in writing (nonelectronic) must be presented on a tamper-resistant pad, as required by Section 1903(i)(23) of the Social Security Act (42 U.S.C. Section 1396b(i)(23)).

a. Prescriber Qualifications

Payment is made for drugs prescribed by a legally qualified practitioner (physician, dentist, podiatrist, therapeutically certified optometrist, physician assistant, or advanced registered nurse practitioner) within the limits prescribed by law and in policies established by the Department.

For prescriptions by a therapeutically certified optometrist, this includes only the following:

- Topical and oral antimicrobial agents
- Topical and oral antihistamines
- Topical and oral antiglaucoma agents
- Topical and oral analgesic agents
- Topical anesthetic agents
- Topical anti-inflammatory agents

EXCEPTION: In the event of an emergency when the prescriber cannot submit a prior authorization request, the pharmacist may dispense a 72-hour supply of the drug and reimbursement will be made.

The following classes of drugs require prior approval:

- ADD/ADHD/narcolepsy agents
- Alpha$_1$-proteinase inhibitor enzymes
- Alpha-blockers, urospecific (Flomax®, Uroxatral®)
- Amylino mimetic (Symlin®)
- Anti-acne
- Antiemetic-5HT3 receptor antagonists/substance P neurokinin agents
- Anti-fungal
- Antihistamines
- Anti-thrombotics (injectable)
- Becaplermin (Regranex®)
- Benzodiazepines
- Biologicals for ankylosing spondylitis
- Biologicals for arthritis
- Biologicals for inflammatory bowel disease
- Biologicals for plaque psoriasis
- Digestive enzymes
- Dornase Alfa (Pulmozyme®)
- Eplerenone (Inspra®)
- Ergotamine derivatives
- Erythropoiesis stimulating agents
- Granulocyte colony stimulating factor agents
- Extended release formulations
- Fentanyl, short-acting oral products
- Growth hormones
- Incretin mimetic (Byetta®)
- Insulin pens, pre-filled pens
- Isotretinoin (oral)
- Ketorolac
- Linezolid (Zyvox®)
- Lipase inhibitor drugs
- Muscle relaxants
- Narcotic agonist-antagonist nasal sprays
- Nicotine replacement products
- Nonparenteral vasopressin derivatives of posterior pituitary hormone products
- Nonpreferred drugs
- Nonsteroidal anti-inflammatory drugs

- Omalizumab (Xolair®)
- Oxycodone CR/ER (OxyContin®)
- Palivizumab Synagis®
- Pregabalin (Lyrica®)
- Proton pump inhibitors
- Pulmonary arterial hypertension agents
- Sedative/hypnotics-non-benzodiazepine
- Selected brand name drugs
- Serotonin 5-HT1-receptor agonists
- Short-acting oral fentanyl products
- Tretinoin products (topical)
- Varenicline (Chantix™)
- Vitamins, minerals and multiple vitamins

See REQUEST FOR PRIOR AUTHORIZATION for forms and instructions.

The specific criteria for approval of a prior authorization request are defined in the subsections that follow. The prior authorization criteria are also available in chart format on the web site www.iowamedicaidpdl.com.

The IME Drug Prior Authorization Unit will consider other conditions as listed in the compendia on an individual basis after reviewing documentation submitted regarding the medical necessity.

a. ADD/ADHD/Narcolepsy Agents

Prior authorization is required for attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD), and narcolepsy agents for members 21 years of age or older.

The psychostimulant category includes amphetamine salt combinations, atomoxetine, dexmethylphenidate HCl, dextroamphetamine, methamphetamine HCl, methylphenidate HCl, modafinil, and pemoline.

Prior approval shall be granted if there is documentation of one of the following:

- Attention deficit disorder
- Attention deficit hyperactivity disorder
- Narcolepsy

b. Alpha$_1$-Proteinase Inhibitor Enzymes

Prior authorization is required for alpha$_1$-proteinase inhibitor enzymes. Payment will be authorized only for cases in which there is a diagnosis of congenital alpha$_1$-proteinase inhibitor (alpha$_1$-PI; alpha$_1$-antitrypsin) deficiency with clinically demonstrable panacinar emphysema.

Payment for a nonpreferred alpha$_1$-proteinase inhibitor enzyme will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.

c. Alpha-Blockers (Urospecific)

Prior authorization is required for urospecific alpha-blockers (Flomax®, Uroxatral®). Payment will be authorized only for members who:

- Have documentation of previous trials and therapy failure with a preferred alpha$_1$-adrenergic blocker; or
- Have a history of postural hypotension or hypotension; or
- Use antihypertensive or other medication that may exacerbate hypotension.

d. Amylino Mimetic (Symlin®)

Prior authorization is required for amylino mimetics (Symlin®). Payment will be considered under the following conditions:

- Diagnosis of Type 1 or Type 2 diabetes mellitus,
- Concurrent use of insulin therapy,
- Documentation of blood glucose monitoring three or more times daily,
- Inadequate reduction in HbgA1C despite multiple titration with basal/bolus insulin-dosing regiments.

Initial authorizations will be approved for six months. Additional prior authorizations will be considered on an individual basis after review of medical necessity and documented improvement in HbgA1C since the beginning of the initial prior authorization period.

e. Anti-Acne Products

Prior authorization is required for **all** prescription topical acne products for the treatment of mild to moderate acne vulgaris.

Payment for **nonpreferred** topical acne products will be authorized only for cases with documentation of previous trial and therapy failures with a preferred agent. Before the initiation of a prescription product:

- An initial treatment failure of an over-the-counter benzoyl peroxide product that is covered by the Medicaid program is required; or
- Evidence must be provided that use of these agents would be medically contraindicated.

If the patient presents with a preponderance of comedonal acne, tretinoin products may be used as first-line agents with prior authorization.

f. Antiemetic-5HT3 Receptor Agonists/Substance P Neurokinin Agents

Prior authorization is required for **preferred** antiemetic-5HT3 receptor antagonists/substance P neurokinin medications for quantities exceeding the following dosage limits per month.

- Aprepitant/Emend®:
  - Four 125 mg capsules
  - Eight 80 mg capsules
- Dolasetron/Anzemet®:
  - Five 50 mg tablets
  - Five 100 mg tablets
- Granisetron/Kytril®:
  - Eight 1 mg tablets
  - 30 mL oral solution (1mg/5mL)
  - Eight vials (1mg/mL)
  - Two vials (4mg/mL)
- Ondansetron ODT/Zofran ODT®:
  - Twelve 4 mg tablets
  - Twelve 8 mg tablets

- Ondansetron/Zofran®:
  - Twelve 4 mg tablets
  - Twelve 8 mg tablets
  - Four 24 mg tablets
  - 50 mL/month oral solution (4mg/5ml)
  - Four 20 mL vials (2mg/mL)
  - Eight 2 mL vials (2mg/mL)
- Palonosetron/Aloxi®: Four vials (0.25 mg/mL)

Payment for antiemetic-5HT3 receptor antagonists/substance P neurokinin agents beyond these limits will be considered on an individual basis after review of submitted documentation.

NOTE: Aprepitant (Emend®) is payable only when used in combination with other antiemetic agents (5-HT3 medication and dexamethasone) for patients receiving highly emetogenic cancer chemotherapy.

Prior authorization is required for all **nonpreferred** antiemetic-5HT3 receptor antagonists/substance P neurokinin medications beginning the first day of therapy. Payment for nonpreferred medications will be authorized only for cases in which there is documentation of previous trials and therapy failure with a preferred agent in this class.

g. Anti-Fungal Therapy

Prior authorization is not required for **preferred** oral anti-fungal therapy for a cumulative 90 days of therapy per 12-month period per patient.

Payment for any oral anti-fungal therapy beyond this limit will be authorized in cases where the patient has a diagnosis of an immunocompromised condition or a systemic fungal infection. This prior authorization requirement does not apply to nystatin.

Prior authorization is required for all **nonpreferred** oral anti-fungal therapy beginning the first day of therapy. Payment for a nonpreferred oral anti-fungal agent will be authorized only for cases with documentation of previous trial and therapy failure with a preferred agent.

h. Antihistamines

Prior authorization is required for all **nonpreferred** antihistamines and preferred second-generation prescription antihistamines.

- Members aged 21 or older must have two unsuccessful trials with an antihistamine that does not require prior authorization before the approval of a nonpreferred first-generation or preferred second-generation prescription antihistamine. One of the trials must be loratadine.

  Before approval of a nonpreferred second-generation antihistamine, the member must also have an unsuccessful trial with a preferred second-generation prescription antihistamine.

- Members aged 20 or younger must have an unsuccessful trial of loratadine before the approval of a nonpreferred first-generation or preferred second-generation prescription antihistamine.

  Before approval of a nonpreferred second-generation antihistamine, the member must also have an unsuccessful trial with a preferred second-generation prescription antihistamine.

The required trials may be overridden when documentation is provided that the use of these agents would be medically contraindicated.

i. Anti-Thrombotics

Prior authorization will be required for all **nonpreferred** injectable anti-thrombotic agents beginning the first day of therapy. Payment for nonpreferred anti-thrombotic injectable agents will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.

Prior authorization is required for use of any **preferred** injectable anti-thrombotic agent longer than 10 consecutive days. Payment for usage of injectable anti-thrombotic agents beyond this limit will be authorized for cases in which there is a clinical diagnosis of:

- Pregnancy or planned pregnancy
- Cancer-associated thromboembolic disease
- History of thrombotic event while on anticoagulant therapy
- Anti-thrombin III deficiency
- Total hip arthroplasty
- Warfarin allergy

j. Becaplermin (Regranex®)

Prior authorization is required for Regranex®. Payment for new prescriptions will be authorized for ten weeks for patients who meet the following criteria:

- Diagnosis of lower extremity diabetic neuropathic ulcers that extend into the subcutaneous tissue or beyond.
- Inadequate response to two weeks of wound debridement and topical moist wound dressing.

Authorization will be approved beyond ten weeks for patients whose wound has decreased in size by 30% after ten weeks.

k. Benzodiazepines

Prior authorization is required for **nonpreferred** single-source benzodiazepines.

Payment for nonpreferred benzodiazepines will be authorized in cases with documentation of previous trial and therapy failure with two preferred products. If a long-acting medication is requested, one of the therapeutic trials must include the immediate release form of the requested benzodiazepine.

Prior authorization will be approved for up to 12 months for documented:

- Generalized anxiety disorder
- Panic attack with or without agoraphobia
- Seizure
- Nonprogressive motor disorder
- Dystonia

Prior authorization requests will be approved for up to a three-month period for all other diagnoses related to the use of benzodiazepines.

l. Biologicals for Ankylosing Spondylitis

Prior authorization is required for biologicals used for ankylosing spondylitis. Payment will be considered following an inadequate response to a preferred NSAID.

Prior authorization is required for all **nonpreferred** biologicals for ankylosing spondylitis as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for nonpreferred biologicals for ankylosing spondylitis will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent.

m. Biologicals for Arthritis

Prior authorization is required for biologicals used for arthritis. Payment will be considered following an inadequate response to a preferred disease modifying antirheumatic drug such as:

- Hydroxycholoroquine,
- Sulfasalazine,
- Methotrexate,
- Leflunomide,
- D-penicillamine,
- Azathioprine,
- Oral gold, or
- Intramuscular gold.

Prior authorization is required beginning the first day of therapy for all **nonpreferred** biologicals for arthritis as indicated on the Iowa Medicaid Preferred Drug List. Payment for nonpreferred biologicals for arthritis will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent.

n. Biologicals for Inflammatory Bowel Disease

Prior authorization is required for biologicals used for inflammatory bowel disease.

Prior authorization is required for all **nonpreferred** biologicals for inflammatory bowel disease as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for nonpreferred biologicals for inflammatory bowel disease will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent.

- Crohn's disease. Payment will be considered following an inadequate response to a preferred conventional therapy such as aminosalicylates (mesalamine, sulfasalazine), corticosteroids, azathioprine/6-mercaptopurine, or methotrexate.

- Ulcerative colitis (moderate to severe). Payment will be considered following an inadequate response to a preferred conventional therapy such as aminosalicylates, corticosteroids, or azathioprine/ 6-mercaptopurine.

o. Biologicals for Plaque Psoriasis

Prior authorization is required for biologicals used for plaque psoriasis. Payment will be considered following an inadequate response to phototherapy, systemic retinoids (oral isotretinoin), methotrexate, or cyclosporine.

Prior authorization is required beginning the first day of therapy for all **nonpreferred** biologicals for plaque psoriasis as indicated on the Iowa Medicaid Preferred Drug List. Payment will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent.

p. Digestive Enzymes

Prior authorization is required for all digestive enzymes.

Payment for **preferred** digestive enzymes will be authorized only for cases in which there is a clinical diagnosis of malabsorption due to pancreatic insufficiency.

Payment for **nonpreferred** digestive enzymes will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.

q. Dornase Alfa (Pulmozyme®)

Prior authorization is required for Pulmozyme®. Payment will be authorized only for cases in which there is a diagnosis of cystic fibrosis.

r. Eplerenone (Inspra®)

Prior authorization is required for Inspra®. Payment will be authorized only in cases where there is documented trial and therapy failure on Aldactone® or documented cases of gynecomastia from Aldactone® therapy.

s. Ergotamine Derivatives

Prior authorization is required for preferred ergotamine derivatives used for migraine headache treatment for quantities exceeding 18 unit doses of tablets, injections, or sprays per 30 days.

Payment for ergotamine derivatives for migraine headache treatment beyond this limit will be considered on an individual basis after review of submitted documentation. Prior authorization will be required for all nonpreferred ergotamine derivatives beginning the first day of therapy.

Payment for nonpreferred ergotamine agents will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. For consideration, the following information must be supplied:

- The diagnosis requiring therapy.
- Documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications.

t. Erythropoiesis Stimulating Agents

Prior authorization is required for erythropoiesis stimulating agents prescribed for outpatients for the treatment of anemia.

Payment for **nonpreferred** erythropoiesis stimulating agents will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.

Patients who meet all of the following criteria may receive prior authorization for the use of erythropoiesis stimulating agents:

- Hemoglobin/hematocrit less than 10/30 percent respectively. If renewal of prior authorization is being requested, hemoglobin/ hematocrit greater than 12/36 percent will require dosage reduction or discontinuation.

  Consideration will be given for continuing therapy for higher hemoglobin/hematocrit values on an individual basis after reviewing medical documentation submitted. Hemoglobin/hematocrit laboratory values must be dated within six weeks of the prior authorization request.

- Transferrin saturation greater than or equal to 20 percent (transferrin saturation is calculated by dividing serum iron by the total iron binding capacity), ferritin levels greater than or equal to 100 mg/mL, or on concurrent therapeutic iron therapy.

  Transferrin saturation or ferritin levels must be dated within three months of the prior authorization request.

- For HIV-infected patients, the endogenous serum erythropoietin level must be less than or equal to 500 mU/mL to initiate therapy.
- No evidence of untreated GI bleeding, hemolysis, or vitamin B-12, iron or folate deficiency.

u. Extended-Release Formulations

Payment for an extended-release formulation will be considered only when there is documentation of previous trial and therapy failure with the immediate-release product of the same chemical entity, unless evidence is provided that use of the immediate-release product would be medically contraindicated. Prior authorization is required for Seroquel® XR.

v. Fentanyl, Short-Acting Oral Products

Prior authorization is required for short-acting oral fentanyl products. Payment will be authorized only if the diagnosis is for breakthrough cancer pain in opioid-tolerant patients. This product carries a Black Box Warning.

Actiq® and Fentora® are indicated only for the management of breakthrough cancer pain in patients with malignancies who are already receiving and tolerant to opioid therapy for their underlying persistent cancer pain.

Actiq® and Fentora® are contraindicated in the management of acute or postoperative pain. Because life-threatening hypoventilation could occur at any dose in patients not taking chronic opiates, do not use these products for patients who are not opioid-tolerant.

w. Granulocyte Colony Stimulating Factor Agents

Prior authorization is required for therapy with granulocyte colony stimulating factor agents.

Payment for **nonpreferred** granulocyte colony stimulating factor agents will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent. Laboratory values for complete blood and platelet count must be contained as directed by the manufacturer's instructions.

Dosage reduction and discontinuation of therapy may be required based on the manufacturer's guidelines. Payment shall be authorized for one of the following uses:

- Prevention or treatment of febrile neutropenia in patients with malignancies who are receiving myelosuppressive anticancer therapy.
- Treatment of neutropenia in patients with malignancies undergoing myeloablative chemotherapy followed by bone marrow transplant.
- Mobilization of progenitor cells into the peripheral blood stream for leukapheresis collection to be used after myeloablative chemotherapy.
- Treatment of congenital, cyclic, or idiopathic neutropenia in symptomatic patients.

x. Growth Hormones

Prior authorization is required for therapy with growth hormones. Payment for **nonpreferred** growth hormones will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.

All of the following criteria must be met for approval for prescribing of growth hormones:

- Standard deviation of 2.0 or more below mean height for chronological age.
- No intracranial lesion or tumor diagnosed by MRI.
- Growth rate below five centimeters per year.
- Bone age 14-15 years or less in females or 15-16 years or less in males.
- Epiphyses open.
- Failure of any two stimuli tests to raise the serum growth hormone level above ten nanograms per milliliter.

Prior authorization will be granted for 12-month periods per member as needed.

If the request is for Zorbtive® [somatropin (rDNA origin) for injection], approval will be granted for the treatment of short bowel syndrome in patients receiving specialized nutritional support. Zorbtive® therapy should be used in conjunction with optimal management of short bowel syndrome.

y. Incretin Mimetic (Byetta®)

Prior authorization is required for incretin mimetics (Byetta®). Payment will be considered under the following conditions:

- Diagnosis of type 2 diabetes mellitus.
- Unless otherwise contraindicated, the member has not achieved glycemic goals using a combination of two or more antidiabetic medications (metformin, sulfonylurea, or thiazolidinedione) at maximum tolerated doses.

Initial authorizations will be approved for six months. Additional prior authorizations will be considered on an individual basis after review of medical necessity and documented improvement in glycemic control since the initial prior authorization.

z. Insulin, Pre-filled Pens

Prior authorization is required for pre-filled insulin pens. Prior authorization is granted when documentation indicates:

- The member's visual or motor skills are impaired to such that the member cannot accurately draw up the insulin, and
- There is no caregiver available to provide assistance.

Prior authorization for **nonpreferred** insulin pens will be granted only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.

aa. Isotretinoin (Oral)

Prior authorization is required for oral isotretinoin therapy. Payment will be approved for preferred oral isotretinoin products for acne under the following conditions:

- There are documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy. Documented trials and therapy failures of systemic antibiotic therapy and topical tretinoin therapy are not required for approval for treatment of acne conglobata.
- Patients and providers must be registered in, and meet all requirements of, the iPLEDGE (www.ipledgeprogram.com/) risk management program.

Payment for nonpreferred oral isotretinoin products will be authorized only for cases in which there is documentation of trials and therapy failure with a preferred agent. Initial authorization will be granted for up to 20 weeks. A minimum of two months without therapy is required to consider subsequent authorizations.

bb. Ketorolac (Oral)

Prior authorization is required for ketorolac tromethamine, a nonsteroidal anti-inflammatory drug indicated for short-term management of moderately severe, acute pain (up to five days). It is NOT indicated for minor or chronic conditions. This product carries a Black Box Warning.

Initiate therapy with IV/IM and use oral ketorolac tromethamine only as a continuation therapy to ketorolac tromethamine IV/IM. The combined duration of use of IV/IM and oral is not to exceed five days. Payment will be approved for the preferred product under the following conditions:

- For oral therapy, documentation of recent IM/IV ketorolac tromethamine injection including administration date and time, and the total number of injections given.
- Request falls within the manufacturer's dosing guidelines. Maximum oral dose is 40mg/day. Maximum IV/IM dose is 120mg/day. Maximum duration of therapy is 5 days per month.
- Diagnosis indicating moderately severe, acute pain.

Payment for a non-preferred product will be authorized only for cases in which there is documentation of trial and therapy failure with the preferred agent.

cc. Linezolid (Zyvox®)

Prior authorization is required for linezolid (Zyvox®). Payment for Zyvox® will be authorized when there is documentation that:

- The prescriber is an infectious disease physician or has consulted an infectious disease physician. (Telephone consultation is acceptable.)
- The member is being treated for one of the following diagnoses:
  - Vancomycin-resistant enterococcus (VRE) when no alternative regimens with documented efficacy are available and VRE is not in lower urinary tract.*
  - Methicillin-resistant staphylococcus aureus (MRSA) when the patient is intolerant to vancomycin.**
  - Methicillin-resistant staphylococcus epidermis (MRSE) when the patient is intolerant to vancomycin.**
- Red-man's syndrome (histamine-mediated), refractory to traditional countermeasures (e.g., prolonged IV infusion, premedicated with diphenhydramine).

* VRE in the lower urinary tract is considered pathogenic and may be treated with linezolid if severe renal insufficiency exists or the patient is receiving hemodialysis or has known hypersensitivity to nitrofurantoin.

**Severe intolerance to vancomycin is defined as: Severe rash, immune-complex-mediated, determined to be directly related to vancomycin administration.

dd. Lipase Inhibitor Drugs for Weight Loss

Prior authorization is required for lipase inhibitor drugs. Payment for lipase inhibitor drugs will be authorized for the clinical diagnosis of hyperlipidemia. Requests for lipase inhibitor drugs for weight loss must include documentation showing:

- Failure of other weight loss programs,
- Body mass index (BMI) equal to or greater than 30,
- One or more comorbidity conditions, and
- A weight management plan that includes diet and exercise.

Prior authorization may be given for up to six months. Additional prior authorizations may be given on an individual basis after review of medical necessity and documented significant weight loss (at least 10 percent) from the individual's weight at the beginning of the previous prior authorization period.

ee. Muscle Relaxants

Prior authorization is required for nonpreferred muscle relaxants. Payment for **nonpreferred** muscle relaxants will be authorized only for cases in which there is documentation of previous trials and therapy failure with at least three preferred muscle relaxants.

ff. Narcotic Agonist-Antagonist Nasal Sprays

Prior authorization is required for narcotic agonist-antagonist nasal sprays. The member's diagnosis must be supplied for consideration.

If the use is for the treatment of migraine headaches, documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications must be provided. There must also be documented treatment failure or contraindication to triptans for the acute treatment of migraines.

For other pain conditions, there must be documentation of treatment failure or contraindication to oral administration.

Payment for nonpreferred narcotic agonist-antagonist nasal sprays will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.

Quantities are limited to 2 bottles or 5 milliliters per 30 days. Payment for narcotic agonist-antagonist nasal sprays beyond this limit will be considered on an individual basis after review of submitted documentation.

gg. Nicotine Replacement Products

Prior authorization is required for over-the-counter nicotine replacement patches and nicotine gum. Requests for authorization must include:

- Diagnosis of nicotine dependence and referral to the Quitline Iowa program for counseling.
- Confirmation of enrollment in the Quitline Iowa counseling program is required for approval.
- Following the first 28 days of therapy, continuation is available only with documentation of ongoing participation in the Quitline Iowa program.

Approvals will be granted only for patients 18 years of age and older.

- The maximum allowed duration of therapy is 12 weeks within a 12-month period.
- A maximum quantity of 14 nicotine replacement patches or 110 pieces of nicotine gum (or equivalent combination) may be dispensed with the initial prescription.
- Subsequent prescription refills will be allowed at a four-week supply at one unit per day of nicotine replacement patches or 330 pieces of nicotine gum (or equivalent combination).
- The 72-hour emergency supply rule does not apply for drugs used for the treatment of smoking cessation.

hh. Nonparenteral Vasopressin Derivatives of Posterior Pituitary Hormone Products

Prior authorization is required for nonparenteral vasopressin derivatives of posterior pituitary hormone products. Payment for nonparenteral vasopressin derivatives of posterior pituitary hormone products will be authorized for the following diagnoses:

- Diabetes insipidus
- Hemophilia A
- Von Willebrand's Disease

Payment for oral vasopressin derivatives of posterior pituitary hormone products used in the treatment of primary nocturnal enuresis will be authorized for patients who are six years of age or older for periods of six months.

Approvals will be granted for subsequent six-month periods only after a drug-free interval to assess the need for continued therapy.

Payment for **nonpreferred** nonparenteral vasopressin derivatives will be authorized only for cases in which there is documentation of trial and therapy failure with a preferred agent.

ii. Nonpreferred Drugs

Prior authorization is required for nonpreferred drugs as specified on the Iowa Medicaid Preferred Drug List.

Payment for a nonpreferred medication will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent, unless evidence is provided that use of these agents is medically contraindicated.

jj. Nonsteroidal Anti-Inflammatory Drugs

Prior authorization is required for all non-preferred nonsteroidal anti-inflammatory drugs and all non-preferred COX-2 inhibitors. Prior authorization is not required for preferred nonsteroidal anti-inflammatory drugs.

- Requests for a non-preferred nonsteroidal anti-inflammatory drug must document previous trials and therapy failures with at least two preferred nonsteroidal anti-inflammatory drugs.
- Requests for a non-preferred COX-2 inhibitor must document previous trials and therapy failures with two COX-2 preferentially selective nonsteroidal anti-inflammatory drugs.

kk. Omalizumab (Xolair®)

Prior authorization is required for omalizumab (Xolair®). Payment for Xolair® will be authorized for members aged 12 or older when there is a diagnosis of moderate to severe persistent asthma and documentation of previous trial and therapy failure with therapeutic doses of inhaled steroids.

ll. Oxycodone CR/ER (OxyContin®)

Extended release oxycodone/OxyContin® is non-preferred except for members being treated for cancer related pain. For all other diagnoses, a previous trial with a preferred long-acting narcotic will be required before consideration.

Extended release oxycodone/OxyContin® should be dosed every 12 hours. Prior authorization for extended release oxycodone/OxyContin® at any dose twice daily for cancer related pain will be approved.

For extended release oxycodone/OxyContin® requests that require more than two tablets per day of the same strength or for more than two strengths per month, the prescriber must provide information to document the need for the medication at the prescribed dosage or quantity.

mm. Palivizumab (Synagis®)

Prior authorization is required for therapy with palivizumab. Payment for palivizumab will be considered for patients who meet one of the following criteria:

- **Chronic lung disease (CLD)**

  Patient is less than 24 months of age at start of therapy and has chronic lung disease of prematurity (i.e. bronchopulmonary dysplasia) requiring medication (bronchodilator, corticosteroid, or diuretic therapy) or oxygen within six months before the anticipated start of RSV season.

- **Prematurity**

  Patient is less than 12 months of age at start of therapy with a gestational age of less than or equal to 28 weeks.

  Patient is less than 6 months of age at start of therapy with a gestational age between 28 weeks and 31 weeks.

  Patient is less than 6 months of age at start of therapy with a gestational age of 32 weeks to 35 weeks and has at least two risk factors.

- **Congenital heart disease (CHD)**

  Patient is less than 24 months of age at start of therapy and has hemodynamically significant congenital heart disease further defined by any of the following:

  - Receiving medication to control congestive heart failure,
  - Moderate to severe pulmonary hypertension, or
  - Cyanotic congenital heart disease.

- **Severe immunodeficiency**

  Patient is less than 24 months of age at start of therapy and has severe immunodeficiencies (e.g., severe combined immunodeficiency or advanced acquired immunodeficiency syndrome).

nn. Pregabalin (Lyrica®)

Prior authorization is required for pregabalin (Lyrica®). Payment will be considered under the following conditions:

- A diagnosis of partial onset seizures, as adjunct therapy.
- A diagnosis of post-herpetic neuralgia and previous treatment failure with at least two of the following agents: tricyclic antidepressant, topical lidocaine, or gabapentin.
- A diagnosis of diabetic peripheral neuropathy and previous treatment failure with at least two of the following agents: tricyclic antidepressant, topical lidocaine, tramadol, or gabapentin.
- A diagnosis of fibromyalgia and a previous treatment failure with a preferred agent at adequate doses to treat fibromyalgia.

oo. Proton Pump Inhibitors

Prior authorization is not required for the **preferred** proton pump inhibitors (PPI) for a cumulative 60 days of therapy per 12-month period.

Prior authorization will be required beginning the first day of therapy for all **nonpreferred** proton pump inhibitors as indicated on the Iowa Medicaid Preferred Drug List. Payment for a nonpreferred proton pump inhibitor will be authorized only for cases with documentation of previous trial and therapy failure with three preferred products.

Prior authorization is required for **any** PPI usage longer than 60 days or more frequently than one 60-day course per 12-month period. The 12-month period is patient-specific and begins 12 months before the requested date of prior authorization.

Payment for usage beyond these limits will be authorized for cases in which there is a diagnosis of:

- Specific hypersecretory conditions (Zollinger-Ellison syndrome, systemic mastocytosis, multiple endocrine adenomas).
- Barrett's esophagus.
- Erosive esophagitis.
- Symptomatic gastroesophageal reflux after documentation of previous trials and therapy failure with at least one histamine H_2-receptor antagonist at full therapeutic doses.
- Recurrent peptic ulcer disease after documentation of previous trials and therapy failure with at least one histamine H_2-receptor antagonist at full therapeutic doses and with documentation of either failure of Helicobacter pylori treatment or a negative Helicobacter pylori test result.

Prior authorization is not required for Prevacid granules for oral suspension or SoluTabs for children age 12 years old or younger for the first 60 days of therapy. Prior authorization is required for Prevacid granules for oral suspension and SoluTabs for patients over 12 years of age beginning day one of therapy.

Authorization for Prevacid granules for oral suspension and Solutabs will be considered for patients who cannot tolerate a solid oral dosage form.

pp. Pulmonary Arterial Hypertension Agents

Prior authorization is required for agents used to treat pulmonary hypertension. Payment will be approved for the diagnosis of pulmonary arterial hypertension.

qq. Sedative/Hypnotics-Non-Benzodiazepine

Prior authorization is required for **preferred** nonbenzodiazepine sedative/hypnotic medications for quantities exceeding 15 units per 30 days. Payment for nonbenzodiazepine sedative/hypnotics beyond this limit will be considered when there is:

- A diagnosis of chronic insomnia (insomnia lasting six months or more) following at least a two-consecutive-month trial of an approved quantity (15/30) of the requested drug.
- Medications with a side effect of insomnia (i.e., stimulants) are decreased in dose, changed to a short acting product, or discontinued.
- Enforcement of good sleep hygiene is documented.
- All medical, neurological, and psychiatric disease states causing chronic insomnia are being adequately treated with appropriate medication at therapeutic doses.

Prior authorization is required for all **nonpreferred** nonbenzodiazepine sedative/hypnotics as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for nonpreferred nonbenzodiazepine sedative/hypnotics will be authorized only for cases in which there is documentation of previous trials and therapy failure with two preferred agents.

rr. Selected Brand Name Drugs

Prior authorization is required for selected brand-name drugs, as determined by the Department, for which there is available an "A" rated bioequivalent generic product, as determined by the federal Food and Drug Administration, unless the brand drug has been designated by the Department as preferred (payable) under the Iowa Medicaid Preferred Drug List.

The list of selected brand-name drugs includes the drugs on the Federal Upper Limit (FUL) list and the State Maximum Allowable Cost (SMAC) list at www.mslciowa.com.

For prior authorization to be considered, the prescriber must certify that the specific brand is medically necessary for the particular patient and provide evidence of an adverse reaction, contraindication, or treatment failure associated with the bioequivalent generic drug.

ss. Serotonin 5-HT1-Receptor Agonists

Prior authorization is required for serotonin 5-HT1-receptor agonists for quantities exceeding 18 unit doses of tablets, syringes, or sprays per 30 days. Payment for serotonin 5-HT1-receptor agonists beyond this limit will be considered on an individual basis after review of submitted documentation.

Prior authorization is required for all **nonpreferred** serotonin 5-HT1-receptor agonists beginning the first day of therapy. Payment for nonpreferred serotonin 5-HT1-receptor agonists will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.

For consideration, the following information must be supplied:

- The diagnosis requiring therapy.
- Documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications.

tt. Tretinoin Products (Topical)

Prior authorization is required for all tretinoin prescription products. Payment for nonpreferred tretinoin products will be authorized only for cases in which there is documentation of previous trial and therapy failure with a preferred agent.

Unless evidence is provided that use of these agents is medically contraindicated, alternatives such as over-the-counter topical benzoyl peroxide and topical or oral antibiotics must first be tried for the following conditions:

- Endocrinopathy
- Mild to moderate acne (non-inflammatory and inflammatory)
- Drug-induced acne

Trials and therapy failure are not required for patients presenting with a preponderance of comedonal acne.

Upon treatment failure with the listed products or if those products are medically contraindicated, tretinoin products will be approved for three months. If tretinoin therapy is effective after the three-month period, approval will be granted for a one-year period.

Skin cancer, lamellar ichthyosis, and Darier's disease diagnoses will receive automatic approval for lifetime use of tretinoin products.

uu. Varenicline (Chantix™)

Prior authorization is required for varenicline (Chantix™). Requests for authorization must include:

- Diagnosis of nicotine dependence and referral to the Quitline Iowa program for counseling.
- Confirmation of enrollment and ongoing participation in the Quitline Iowa counseling program is required for approval and continued coverage.

Approvals will be granted only for patients 18 years of age or older.

- The duration of therapy is initially limited to 12 weeks within a 12-month period.
- For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment will be considered with a prior authorization request. The maximum duration of approvable therapy is 24 weeks within a 12-month period.
- Requests for varenicline to be used in combination with bupropion SR that is FDA-indicated for smoking cessation or nicotine replacement therapy will not be approved.
- The 72-hour emergency supply rule does not apply for drugs used for the treatment of smoking cessation.

vv. Vitamins, Minerals and Multiple Vitamins

Payment for vitamins, minerals, and multiple vitamins for treatment of specific conditions will be approved when:

- A specific vitamin or mineral deficiency disease is diagnosed; or
- A member aged 20 or under has a diagnosed disease that inhibits the nutrition absorption process as a secondary effect of the disease.

Prior approval is not required for a legend product primarily classified as a blood modifier if that product does not contain more than three vitamins and minerals, or for products principally marketed as prenatal vitamin-mineral supplements.

Prior authorization is **not** required for a vitamin and mineral product principally marketed for use as a dietary supplement during pregnancy and lactation.

4. Newly Released Drugs

a. Classes of Drugs Already Reviewed by the P&T Committee

New drug entities (including new generic drugs) and new drug product dosage forms of existing drug entities in therapeutic classes already reviewed by the P&T Committee will be identified weekly and immediately be coded as "Nonpreferred – Prior authorization required" until presented at the next quarterly scheduled P&T Committee meeting.

These prior authorization restrictions will continue through the review process, including while committee recommendations are being made, and lasting until DHS makes a final determination.

- Over-the-counter drugs (list posted at www.iowamedicaidpdl.com)
- Prescription vitamin and minerals, except prenatal vitamins and fluoride preparations
- Weight-loss products

Iowa Medicaid will accept only secondary claims for these drugs. Medicaid should be listed as the secondary insurance for all dual eligibles. All claims should be submitted first to the primary insurance (Medicare Part D PDP).

Iowa Medicaid will **not** pay for any Medicare Part B drugs, such as:

- Oral immunosuppressant drugs,
- Inhalation drugs when used with a nebulizer,
- Oral chemotherapy drugs,
- Oral anti-emetic drugs,
- Blood clotting factors, or
- Epoetin.

A drug for which coverage is available to a dual eligible under Medicare Part A or Part B must be billed to Medicare Part A or Part B.

C. REQUEST FOR PRIOR AUTHORIZATION

The prescriber requests prior authorizations, not the pharmacy. The process is a **prescriber fax-only system** using the forms provided by the Iowa Medicaid Enterprise. The prescriber must request prior authorizations by faxing **800-574-2515**.

A provider help desk is available at (515) 725-1106 (local calls) or 877-776-1567 to answer questions regarding the drug prior authorization process. Requests for prior authorizations will **not** be taken at this number.

1. Prior Authorization Request Forms

Prescribers must use the *Request for Prior Authorization* to request drug prior authorization. Requests require the information designated on the applicable *Request for Prior Authorization*, as follows (click on the linked name to see a sample of the form):

- ADD/ADHD/Narcolepsy Agents, form 470-4116
- Alpha Blockers, Urospecific, form 470-4278
- Amylino Mimetic (Symlin®), form 470-4406

Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
ANTI-ACNE PRODUCTS - TOPICAL

This form is used for both preferred and non-preferred agents.
(PLEASE PRINT –ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Prior authorization is required for all prescription topical acne products for the treatment of mild to moderate acne vulgaris. An initial treatment failure of an over-the-counter benzoyl peroxide product is required prior to the initiation of a prescription product. Note: Benzoyl Peroxide (OTC) does not require a prior authorization and is a covered OTC payable product by Iowa Medicaid.

Preferred

Akne-Mycin
Azelex
BenzamycinPak
Clindamycin
Differin
Erythromycin
Metronidazole Cream
Metrogel
☐ Metrolotion
☐ Plexion
☐ Plexion TS
☐ Rosac
☐ Triaz Cleanser
☐ Triaz Gel 9%
☐ Triaz Pads

Non-Preferred

☐ Benzac AC
☐ Benzac AC Wash
☐ Benzaclin
☐ Benzagel-10
☐ Benzamycin
☐ Brevoxyl
☐ Cleocin-T
☐ Clindagel
☐ Clindamycin Swab
☐ Erythromycin/BPO
☐ Desquam-E
☐ Desquam-X
☐ Finacea
☐ Klaron
☐ Metrocream
☐ Noritate
☐ Rosanil Cleanser
☐ Sodium Sulfa/Sulf
☐ Sulfacet-R
☐ Triaz Gel 3%
☐ Triaz Gel 6%

Other **(specify)** _____ ☐

Strength	**Form (wash, gel, etc.)**	**Usage Instructions**	**Quantity**	**Days Supply**
_____	_____	_____	_____	_____

Diagnosis:_____

Benzoyl peroxide trial: Drug Name_____ Strength_____ Instructions_____

Trial date from:_____ Trial date to:_____

Medical or contraindication reason to override trial requirements:_____

Reason for use of Non-Preferred drug requiring prior approval:_____

_____

Pertinent Lab data:_____

Other relevant information:_____

Possible drug interactions/conflicting drug therapies:_____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin Products

This form is used for both preferred and non-preferred agents.

(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Prior authorization is required for preferred Antiemetic-5HT3 Receptor Antagonists/Substance P Neurokinin medications for quantities exceeding the following dosage limits per month. Payment for Antiemetic-5HT3 Receptor Agonists/Substance P Neurokinin Agents beyond this limit will be considered on an individual basis after review of submitted documentation. Prior authorization will be required for all non-preferred Antiemetic-5HT3 ReceptorAntagonists/ Substance P Neurokinin medications beginning the first day of therapy. Payment for non-preferred medications will be authorized only for cases in which there is documentation of previous trial(s) and therapy failure with a preferred agent in this class. Note: Aprepitant (Emend®) will only be payable when used in combination with other antiemetic agents (5-HT3 medication and dexamethasone) for patients receiving highly emetogenic cancer chemotherapy.

Preferred

Emend	4 - 125mg capsules	☐
	8 – 80mg capsules	☐
Ondansetron	12 – 4mg tablets	☐
	12 – 8mg tablets	☐
	4 – 24mg tablets	☐
	50mL/month – oral solution (4mg/5mL)	☐
	4 – 20mL vials (2mg/mL)	☐
	8 – 2mL vials (2mg/mL)	☐
Ondansetron ODT	12 – 4mg tablets	☐
	12 – 8mg tablets	☐

Non Preferred

Aloxi	4 vials (0.25mg/5mL)	☐
Anzemet	5 – 50mg/100mg tablets	☐
	4 vials (100mg/5mL)	☐
	8 ampules (12.5mg/0.625mL)	☐
Kytril/Granisol/Granisetron	8 – 1mg tablets	☐
	30mL – oral solution (1mg/5mL)	☐
	8 vials (1mg/mL)	☐
	2 vials (4mg/mL)	☐
Zofran (Same quantity limitations as Ondansetron)		☐

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**
_____	_____	_____	_____

Diagnosis:_____

Medical reasoning for therapy exceeding dosage limits: _____

_____

Reason for use of Non-Preferred drug requiring prior approval:_____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
Biologicals for Arthritis

This form is used for both preferred and non-preferred agents.
(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Prior authorization is required for biologicals used for arthritis. Payment will be considered following an inadequate response to a preferred disease modifying antirheumatic drug such as hydroxycholoroquine, sulfasalazine, methotrexate, leflunomide, d-penicillamine, azathioprine, oral gold, or intra-muscular gold. Prior authorization is required for all non-preferred biologicals for arthritis as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred biologicals for arthritis will be considered only for cases in which there is documentation of a previous trial and therapy failure with a preferred agent.

Preferred		**Non-Preferred**			
Enbrel®	☐	Kineret®	☐	Remicade®	☐
Humira®	☐	Orencia®	☐		

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**
_____	_____	_____	_____

Diagnosis:
- ☐ Rheumatoid arthritis, moderate to severe (adult)
- ☐ Psoriatic arthritis (adult)
- ☐ Juvenile rheumatoid arthritis, moderate to severe (Enbrel® only)
- ☐ Juvenile idiopathic arthritis (Humira® for members 4-17 years old; Orencia® for members 6 years of age and older)

Treatment failure with a preferred DMARD product: Trial Drug Name: _____

Trial start date: _____ Trial end date: _____

Failure reason: _____

Reason for use of Non-Preferred drug requiring prior approval:_____

Other medical conditions to consider: _____

_____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
Extended Release Formulations
(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Payment for the extended release formulation will be considered only for cases in which there is documentation of previous trial and therapy failure with the immediate release product of the same chemical entity, unless evidence is provided that use of the immediate release product would be medically contraindicated.

Prior authorization is required for the following extended release formulation(s):

☐ Seroquel XR®

Dosage Instructions:_____ Quantity:_____ Days Supply: _____

Diagnosis:_____

Previous therapy with immediate release product: (include strength and exact date ranges):_____

_____

Reason for failure with immediate release product: _____

_____

Contraindication(s) to using immediate release product: _____

_____

Other relevant information:_____

Possible drug interactions/conflicting drug therapies:_____

_____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
KETOROLAC TROMETHAMINE (TORADOL®)
(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Prior authorization is required for ketorolac tromethamine , a nonsteroidal anti-inflammatory drug indicated for short term (up to five days) management of moderately severe, acute pain. It is NOT indicated for minor or chronic conditions. This product carries a Black Box Warning. Initiate therapy with IV/IM and use oral ketorolac tromethamine only as a continuation therapy to ketorolac tromethamine IV/IM. The combined duration of use of IV/IM and oral is not to exceed five (5) days. Payment will be approved for the preferred product under the following conditions: 1. For oral therapy, documentation of recent IM/IV ketorolac tromethamine injection including administration date and time, and the total number of injections given. 2. Request falls within the manufacturer's dosing guidelines. Maximum oral dose is 40mg/day. Maximum IV/IM dose is 120mg/day. Maximum duration of therapy is 5 days per month. 3. Diagnosis indicating moderately severe, acute pain. Payment for a non-preferred product will be authorized only for cases in which there is documentation of trial and therapy failure with the preferred agent.

PLEASE NOTE THERE IS A BLACK BOX WARNING FOR THIS PRODUCT

Non-Preferred

Ketorolac Tablets ☐
Ketorolac Tromethamine Injection ☐
Toradol ☐

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**
_____	_____	_____	_____ (5 DAYS MAX)

Ketorolac tromethamine IM/IV Administration Date: _____ Admin Time: _____

Diagnosis:

- ❑ **Pain, moderately severe acute**
- ❑ **Pain, chronic**
- ❑ **Other (specify):**_____

Pertinent Lab data:_____

Additional relevant information:_____

Reason for use of Non-Preferred drug requiring prior approval:_____

_____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
NONSTEROIDAL ANTI-INFLAMMATORY DRUGS

This form is used for both preferred and non-preferred agents.

(PLEASE PRINT –ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Prior authorization is required for all non-preferred nonsteroidal anti-inflammatory drugs and all non-preferred COX-2 inhibitors. Prior authorization is not required for preferred nonsteroidal anti-inflammatory drugs. 1. Requests for a non-preferred nonsteroidal anti-inflammatory drug must document previous trials and therapy failures with at least two preferred nonsteroidal anti-inflammatory drugs. 2. Requests for a non-preferred COX-2 inhibitor must document previous trials and therapy failures with two COX-2 preferentially selective nonsteroidal anti-inflammatory drugs.

Preferred (PA required only for bolded products)

Diclofenac Sod.
Diclofenac Sod. EC/DR
Etodolac 400mg/500mg
Fenoprofen
Flurbiprofen
Ibuprofen
Ibuprofen Susp.
Indomethacin
Ketoprofen
Ketoprofen ER
Meloxicam (COX-2)
Nabumetone (COX-2)
Naprosyn Susp.
Naproxen
Naproxen EC/ER
Naproxen Sodium 550mg
Oxaprozin
Piroxicam
Salsalate
Sulindac

Non-Preferred (PA required for all products)

Arthrotec 50 ☐
Arthrotec 75 ☐
Cataflam ☐
Celebrex ☐
Clinoril ☐
Daypro ☐
Diclofenac Pot. ☐
Diclofenac Sod. ER/XR ☐
EC-Naprosyn ☐
Etodolac CR/ER/XR ☐
Flector Patch ☐
Indomethacin ER ☐
Meclofenamate Sod ☐
Mobic ☐
Motrin ☐
Naprelan ☐
Naprosyn ☐
Oruvail ☐
Ponstel ☐
Relafen ☐
Tolmetin Sodium ☐
Voltaren ☐
Voltaren XR ☐
Other (specify) _____ ☐

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**
_____	_____	_____	_____

Diagnosis:_____

Trial 1 multi-source preferred product: Drug Name_____ Strength_____

Dosage Instructions_____ Trial date from:_____ Trial date to:_____

Trial 2 multi-source preferred product: Drug Name_____ Strength_____

Dosage Instructions_____ Trial date from:_____ Trial date to:_____

Medical or contraindication reason to override trial requirements: _____

Reason for use of Non-Preferred drug requiring prior approval:_____

Other relevant information:_____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

- Anti-Acne Products – Topical, form 470-4093
- Antiemetic – 5HT3 Receptor Antagonists/Substance P Neurokinin Agents, form 470-4410
- Antifungal Drugs, form 470-4094
- Antihistamines, form 470-4095
- Anti-Thrombotic Injectables, form 470-4096
- Beclapermin (Regranex®), form 470-4276
- Benzodiazepines, form 470-4117
- Biologicals for Ankylosing Spondylitis, form 470-4521
- Biologicals for Arthritis, form 470-4522
- Biologicals for Inflammatory Bowel Disease, form 470-4523
- Biologicals for Plaque Psoriasis, form 470-4524
- Ergotamine Derivatives, form 470-4097
- Erythropoiesis Stimulating Agents, form 470-4098
- Extended Release Formulations, form 470-4550
- Granulocyte Colony Stimulating Factor, form 470-4099
- Growth Hormones, form 470-4100
- Incretin Mimetic (Byetta®), form 470-4407
- Ketorolac Tromethamine (Toradol®), form 470-4102
- Linezolid (Zyvox®), form 470-4275
- Lipase Inhibitors, form 470-4118
- Miscellaneous, form 470-4104 (used for alpha$_1$-proteinase inhibitor enzymes, digestive enzymes, Inspra®, and Pulmozyne®)
- Muscle Relaxants, form 470-4105
- Narcotic Agonist/Antagonist Nasal Sprays, form 470-4106
- Nicotine Replacement Therapy, form 470-4421
- Nonparenteral Vasopressin Derivatives of Posterior Pituitary Hormone Products, form 470-4107
- Non-Preferred Drug, form 470-4108
- Nonsteroidal Anti-inflammatory Drugs, form 470-4109
- Omalizumab (Xolair®), form 470-4279

- Oral Isotretinoin, form 470-4101
- Oxycodone CR/ER, form 470-4409
- Palivizumab (Synagis®), form 470-4110
- Prefilled Insulin Pens, form 470-4111
- Pregabalin (Lyrica®), form 470-4551
- Proton Pump Inhibitors, form 470-4112
- Pulmonary Arterial Hypertension Agents, form 470-4327
- Sedative/Hypnotics-Non-Benzodiazepine, form 470-4328
- Selected Brand Name Drugs, form 470-4119
- Serotonin 5-HT1-Receptor Agonists, form 470-4113
- Short-Acting Oral Fentanyl Products, form 470-4092
- Tretinoin - Topical, form 470-4114
- Varenicline (Chantix™), form 470-4517
- Vitamins & Minerals, form 470-4115

You can obtain a prior authorization form:

- From the web site www.iowamedicaidpdl.com/index.pl/pa_forms or
- By calling the drug prior authorization help desk at (515) 725-1106 (local calls) or 877-776-1567.

2. Instructions for Completing Request for Drug Prior Authorization

IA Medicaid Member ID #: Copy this number directly from the *Medical Assistance Eligibility Card*. This number must be eight positions in length (seven numeric digits and one alphabetical character).

Patient Name: Provide the first and last name of the patient. Use the *Medical Assistance Eligibility Card* for verification.

Date of Birth (DOB): Copy the patient's date of birth directly from the *Medical Assistance Eligibility* Card. Use two digits for each: month, day, year (i.e., 04/11/67).

Patient Address: Enter the patient's home address.

Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
Oxycodone ER/CR (OXYCONTIN®)

This form is used for both preferred and non-preferred agents.
(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Extended release oxycodone/OxyContin® is non-preferred except for members being treated for cancer related pain. For all other diagnoses, a previous trial with a preferred long-acting narcotic will be required prior to consideration. Extended release oxycodone/OxyContin® should be dosed every 12 hours. For extended release oxycodone/OxyContin® requests that require more than two tablets per day of the same strength or for more than two strengths per month, the prescriber must provide information to document the need for the medication at the prescribed dosage or quantity. Prior authorization for extended release oxycodone/OxyContin® at any dose twice daily for cancer related pain will be approved.

Non-Preferred

OxyContin® ☐

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

If request is for two (2) strengths per month, second strength information:

Strength	Dosage Instructions	Quantity	Days Supply
_____	_____	_____	_____

Diagnosis: _____

Is the member enrolled in Hospice? ❑ No ❑ Yes

Document preferred long acting opioid treatment failure(s) including drug names, strength, exact date ranges and failure reasons:

_____

_____

Medical rationale for therapy exceeding 2 tablets per day (if applicable): _____

_____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____

***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
Pregabalin (Lyrica®)

This form is used for both preferred and non-preferred agents.
(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Prior authorization is required for pregabalin (Lyrica®). Payment will be considered under the following conditions: 1. A diagnosis of partial onset seizures, as adjunct therapy. 2. A diagnosis of post-herpetic neuralgia and previous treatment failure with at least two of the following agents: tricyclic antidepressant, topical lidocaine, or gabapentin. 3. A diagnosis of diabetic peripheral neuropathy and previous treatment failure with at least two of the following agents: tricyclic antidepressant, topical lidocaine, tramadol, or gabapentin. 4. A diagnosis of fibromyalgia and a previous treatment failure with a preferred agent at adequate doses to treat fibromyalgia.

Non-Preferred

Lyrica® ☐

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**
_____	_____	_____	_____

Diagnosis: _____

Trial Drug #1 Name/Dose: _____

Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Trial Drug #2 Name/Dose: _____

Trial start date: _____ Trial end date: _____

Reason for Failure: _____

Other relevant information: _____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____

***MUST MATCH PRESCRIBER LISTED ABOVE**

IMPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

470-4551 (7/08)

Provider Help Desk
1 (877) 776 –1567

FAX Completed Form To
1 (800) 574-2515

Iowa Department of Human Services
REQUEST FOR PRIOR AUTHORIZATION
SEROTONIN 5-HT1 RECEPTOR AGONISTS

This form is used for both preferred and non-preferred agents.

(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Provider NPI: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy

NPI: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Prior authorization is required for preferred serotonin 5-HT1-receptor agonists for quantities exceeding 18 unit doses of tablets, syringes or sprays per 30 days. Payment for serotonin 5-HT1-receptor agonists beyond this limit will be considered on an individual basis after review of submitted documentation. Prior authorization will be required for all non-preferred serotonin 5-HT1-receptor agonists as indicated on the Iowa Medicaid Preferred Drug List beginning the first day of therapy. Payment for non-preferred serotonin 5-HT1-receptor agonists will be authorized only for cases in which there is documentation of previous trials and therapy failures with three preferred agents. For consideration, the following information must be supplied: 1. The diagnosis requiring therapy. 2. Documentation of current prophylactic therapy or documentation of previous trials and therapy failures with two different prophylactic medications.

Preferred (PA required after 18 doses in 30 days)				**Non- Preferred (PA required from Day 1)**			
Imitrex Injectable	☐	Maxalt MLT	☐	Amerge	☐	Treximet	☐
Imitrex Nasal Spray	☐	Relpax	☐	Axert	☐	Zomig	☐
Imitrex Tablets	☐			Frova	☐	Zomig ZMT	☐
Maxalt	☐						

Strength	**Dosage Instructions**	**Quantity**	**Days Supply**
_____	_____	_____	_____

Diagnosis:_____

If Migraine, please **document the current prophylactic therapy or 2 previous trials and therapy failures with two different prophylactic medications** including drug names, strength, exact date ranges and failure reasons: _____

_____

_____

Medical or contraindication reason to override trial requirements: _____

Previous migraine therapy (include drug/dose/duration):_____

_____

Reason for use of Non-Preferred drug requiring prior approval:_____

Other medical conditions to consider:_____

Attach lab results and other documentation as necessary.

Prescriber Signature: _____ Date of Submission: _____

***MUST MATCH PRESCRIBER LISTED ABOVE**

MPORTANT NOTE: In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.

Prescriber Number: Enter the national provider identifier (NPI) of the prescribing practitioner.

Prescriber Name: Enter the name of the prescribing practitioner.

Prescriber Phone Number: Enter the prescriber's office phone number.

Prescriber Address: Enter the prescriber's office address.

Prescriber Fax Number: Enter the prescribing practitioner's office FAX number.

Pharmacy Name: Enter the name of the pharmacy where the prescription will be filled.

Pharmacy Address: Enter the street address and city of the pharmacy.

Pharmacy Phone Number: Enter the phone number of the pharmacy.

Pharmacy NPI: Enter the pharmacy national provider identifier (NPI) number.

NDC: If available, enter the National Drug Code of the product being requested.

Drug Name: Provide the complete drug name of the product being requested.

Strength: Enter the strength of the drug being requested.

Dosage Instructions: Enter the instructions for use for the requested product.

Quantity: Enter the quantity on the prescription (cannot exceed a one-month supply).

Days Supply: Enter the number of days' supply requested (cannot exceed a one-month supply).

FIELD NAME / DESCRIPTION	INSTRUCTIONS
DATE OF BIRTH	**REQUIRED**. Enter the member's birth date using a two-digit entry for each of the following: month, day, and year.
PATIENT GENDER CODE	No entry required.
RELATIONSHIP TO CARDHOLDER	Leave blank.
PHARMACY NAME	**REQUIRED**. Enter the pharmacy's name.
ADDRESS	**REQUIRED**. Enter the pharmacy's street address.
NATIONAL PROVIDER IDENTIFIER (NPI) (PHARMACY NUMBER)	**REQUIRED**. Enter the pharmacy's national provider identifier (NPI).
QUAL (5)	Leave blank.
CITY	**REQUIRED**. Enter the pharmacy's city.
PHONE NUMBER	**OPTIONAL**. Entering the pharmacy's area code and phone number may expedite processing of the claim.
STATE & ZIP CODE	**REQUIRED**. Enter the pharmacy's state and zip code.
FAX NUMBER	**OPTIONAL**. Entering the pharmacy's area code and fax number may expedite processing of the claim.
WORKER'S COMP INFORMATION	Leave blank – all lines.
PRESCRIPTION SERV. REF# (RX NUMBER)	**REQUIRED**. Enter the prescription number you have assigned to the prescription being billed. This number must be **all numeric**. No alpha characters are allowed.
QUAL (8)	Leave blank.
DATE WRITTEN	**REQUIRED**. Enter the date the prescription was written using a two-digit entry for each of the following: month, day, and year.

FIELD NAME / DESCRIPTION	INSTRUCTIONS
DATE OF SERVICE	**REQUIRED**. Enter the date the prescription was filled using a two-digit entry for each of the following: month, day, and year. NOTE: Two prescriptions can be billed on the same claim, but they must have the *same* date written and the date filled.
FILL #	**REQUIRED**. Enter "00" for a new prescription, and 01-99 for refills.
QUANTITY DISPENSED	**REQUIRED**. Give the number of tablets, capsules, etc. or the **metric measurement** for liquids, creams, etc. Be sure the billed quantity, when divided by the number of days' supply, is an appropriate amount for that therapeutic class of drugs. If the quantity is a fractional amount, use a decimal point.
DAYS SUPPLY	**REQUIRED**. Enter the number of days the prescription will last.
PRODUCT/SERVICE ID (NATIONAL DRUG CODE)	**REQUIRED**. Enter the national drug code (NDC) found on the drug's label. All of the numerals in the NDC, including the package size, must be current and exactly match the NDC of the product actually dispensed. Be careful to copy the NDC exactly as it appears, including leading zeros. If the product number is only three digits long, enter a leading zero. For a compound, the word "compound" must appear in this field. List each ingredient, NDC, quantity, and charge on the back of the claim.
QUAL (10)	Leave blank.
DAW CODE (MAC OVERRIDE)	Leave blank.
PRIOR AUTH # SUBMITTED	**CONDITIONAL**. Leave blank unless one of the following applies: 1 = 72 hour supply 4 = Pregnant 5 = Nursing facility vaccine 8 = 30-day override prior authorization drug

FIELD NAME / DESCRIPTION	INSTRUCTIONS
PA TYPE	**CONDITIONAL**. Enter code "2" if a number was entered in the "PRIOR AUTH # SUBMITTED" box. Otherwise, leave blank.
PRESCRIBER ID	**CONDITIONAL**. Enter the national provider identifier (NPI) of the prescribing practitioner.
QUAL (16)	Leave blank.
DUR/PPS CODES	Leave blank.
BASIS COST	**CONDITIONAL**. Enter code "09" to indicate unit dose drug. Otherwise, leave blank.
PROVIDER ID	Leave blank. This information has been provided under "SERVICE PROVIDER ID."
QUAL (15)	Leave blank.
DIAGNOSIS CODE	Leave blank.
QUAL (16)	Leave blank.
OTHER PAYER DATE	**CONDITIONAL**. If the patient has other insurance coverage, enter the date the claim was paid or rejected by the other insurer.
OTHER PAYER ID	Leave blank.
QUAL (17)	Leave blank.
OTHER PAYER REJECT CODES	**CONDITIONAL**. If the patient has other insurance coverage but the claim was rejected, enter the rejection codes assigned by the other insurer (if known).
USUAL & CUSTOMARY CHARGE	**REQUIRED**. Enter the Usual & Customary charge. This information is supplied in the GROSS AMOUNT DUE field.
INGREDIENT COST SUBMITTED	**REQUIRED**. Enter the pharmacy's actual wholesale cost.
DISPENSING FEE SUBMITTED	**REQUIRED**. Enter the pharmacy's usual and customary dispensing fee. Enter zeros if no dispensing fee is charged for the prescription.

FIELD NAME / DESCRIPTION	INSTRUCTIONS
INCENTIVE AMOUNT SUBMITTED	Leave blank.
OTHER AMOUNT SUBMITTED	Leave blank.
SALES TAX SUBMITTED	Leave blank.
GROSS AMOUNT DUE	**REQUIRED**. Enter the **total** charge for this item. The total claim charge must be equal to the sum of the submitted ingredient cost submitted and the submitted dispensing fee.
PATIENT PAID AMOUNT	Leave blank.
OTHER PAYER AMOUNT PAID	**CONDITIONAL**. Enter the amount received from third-party payment, if applicable.
NET AMOUNT DUE	**REQUIRED**. Enter the total price less the deductible amount. NOTE: If resubmitting a claim that is over 12 months old, the word "resubmit" must clearly appear on the claim to avoid denials for timely filing. This procedure can be used only if the original submission was within the last 12 months.
INE NUMBERS	**CONDITIONAL**. When billing for a separate drug dispensed by the pharmacist on the same date of service, use a separate line and follow the instructions for corresponding fields.

3. Claim Attachment Control, Form 470-3969

If you want to submit electronically a claim that requires an attachment, you must submit the attachment on paper using the following procedure:

- Complete form 470-3969, *Claim Attachment Control*. To view a sample of this form on line, click here.

  Complete the "attachment control number" with the same number submitted on the electronic claim. IME will accept up to 20 characters (letters or digits) in this number. If you do not know the attachment control number for the claim, please contact the person in your facility responsible for electronic claims billing.

- **Staple** the additional information to form 470-3969. Do **not** attach a paper claim.

- Mail the *Claim Attachment Control* with attachments to:

  Medicaid Claims
  PO Box 150001
  Des Moines, IA 50315

Once IME receives the paper attachment, it will manually be matched up to the electronic claim using the attachment control number and then processed.

G. EDITS AND SPECIAL BILLING INFORMATION

1. Prospective Drug Utilization Review (Pro-DUR)

The goal of Prospective DUR is to identify potential drug therapy concerns to allow the pharmacist to use professional judgment regarding the need for intervention, such as whether or not to contact the prescribing physician. The following prospective DUR edits will cause claims to deny:

Edit	Number and Message	Reason for the Denial	* Override Provided
Age Edits	75 - PRIOR AUTHORIZATION REQUIRED	Certain medications are only payable for specific age groups. See below	
Cost Effective-ness	75 - PRIOR AUTHORIZATION REQUIRED	Certain strengths should be submitted with more cost effective strengths of the same medication. See below.	
Dosage Form	75 - PRIOR AUTHORIZATION REQUIRED Additional text: NONPREFERRED	Certain dosage forms should be substituted with more cost-effective dosage forms of the same medication. See below.	If there is a reason a particular dosage form cannot be used.
Excessive Days Supply	19 – M/I DAYS SUPPLY Additional text: EXCEEDS ALLOWABLE DAYS SUPPLY	If the supply submitted is greater than 30 days.	Request an exception to policy if there is a valid reason why a supply greater than 30 days is required (i.e. travel).

Edit	Number and Message	Reason for the Denial	* Override Provided
High Dollar Claims	78 - COST EXCEEDS MAXIMUM Additional text: Claim Exceeds $10,000.00, please call POS Helpdesk	All claims submitted in excess of $10,000 will reject. After verifying the quantity and days supply of the claim are correct, contact the Pharmacy POS Help Desk.	A one-time override will be granted if quantity and days supply are accurate and consistent. Additional medical documentation is required for longer term overrides.
High Dose	88 – DUR REJECT MESSAGE Additional text: HIGH DOSE	If the maximum dose as determined by Medi-Span has been exceeded by 150% for 22 therapeutic classes.	If there is verification of the quantity and days supply and of the dose by the prescriber.
Refill Too Soon	79 – REFILL TOO SOON Additional text: RX NUMBER/FILL DATE/NPI OR NABP/DATE FOR NEXT FILL	If less than 75% of the previously paid claim for that medication has not been used (85% for controlled substances, carisoprodol and tramadol-containing products).	If there is a change in dose; lost, stolen or destroyed drug; or travel.
Tablet Splitting	19 – M/I DAYS SUPPLY Additional text: MUST SPLIT TABLETS	Certain medications that are scored and easily halved should be split to facilitate more cost-effective use of the drugs.	If the patient is unable to break the tablets or the dose cannot be achieved by switching tablet strength.
Therapeutic Duplication	88 – DUR REJECT MESSAGE Additional text: SITUATIONAL	If a second claim submitted is a therapeutic duplication of a drug already submitted and reimbursed. See below.	Overlapping claims will be considered on an individual basis.

* Always verify the quantity and days supply on the claim are correct; then for an override contact: Pharmacy POS Help Desk at 877-463-7671 or 515-725-1107 (local).

a. Age Edits

Certain medications are payable only for specific age groups:

- Drugs that are FDA-indicated for the treatment of Alzheimer's dementia, (donepezil, galantamine, memantine, and rivastigmine) are payable only for members 40 years of age and older. A prior authorization is required for patients with Alzheimer's dementia who are under 40 years of age.
- Imiquimod (Aldara) is payable only for members who are 12 years of age and older per FDA label instructions. A prior authorization is required for those patients younger than 12.
- Modafinil (Provigil) is payable only for members 16 years of age and older per FDA-approved labeling.
- Pimecrolimus (Elidel) is payable only for members 2 years of age and older per FDA-approved labeling.
- Tacrolimus (Protopic) 0.03% ointment is payable only for members 2 years of age and older per FDA-approved labeling.
- Tacrolimus (Protopic) 0.1% ointment is payable only for members 16 years of age and older per FDA-approved labeling.

b. Cost Effectiveness Edit

Antivert tablet	50 mg	Deny. Use two meclizine HC1 25 mg tablets.
Benzonatate capsule	200 mg	Deny. Use two benzonatate 100 mg capsules.
Buspirone tablet	30 mg	Deny. Use two buspirone 15 mg tablets.
Clindamycin capsule	300 mg	Deny. Use multiples of clindamycin 150 mg capsule.
Hydroxyzine HC1 tablets	25 & 50 mg	Deny. Use hydroxyzine pamoate 25 & 50 mg capsules.
Hydroxyzine pamoate capsules	100 mg	Deny. Use hydroxyzine pamoate 50 mg capsules.
Prozac or fluoxetine HC1 capsules	40 mg	Deny. Use (2) fluoxetine HC1 20 mg capsules.
Rheumatrex		Deny. Use methotrexate.

Revised 1/15/05

c. Dosage Form Edits

Prozac tablets	fluoxetine	20 mg	Deny. Use the capsule dosage form.
Zantac capsules	ranitidine	150 mg	Deny. Use the tablet dosage form.
Zantac capsules	ranitidine	300 mg	Deny. Use the tablet dosage form.

Revised 1/29/04

d. Excessive Days Supply

The claim rejects if the supply submitted is greater than 30 days. If there is a valid reason why a supply greater than 30 days is required (i.e. travel), request an exception to policy.

e. High-Dollar Claims

All claims submitted through the pharmacy point of sale system in excess of $10,000 will reject with a denial message stating, "Claim exceeds $10,000, please call POS Help Desk at 877-463-7671 or 725-1107 locally."

After verifying the quantity and days supply on the claim are correct, contact the Pharmacy POS Help Desk consideration of an override. A technician or pharmacist will review the information submitted and determine if an override shall be issued.

As a part of this process, the Iowa Medicaid Surveillance Utilization Recovery (SURS) Unit may request additional medical documentation regarding the case from the prescriber or pharmacy. It is not the intent of this new policy to hinder or deny the delivery of pharmaceutical products to Iowa Medicaid Members; rather, it is to help ensure that proper billing procedures are being followed.

f. High Dose

Payment will be denied for drugs in the following therapeutic classes if the maximum dose as determined by Medi-Span has been exceeded by 150%. To obtain an override, the prescriber must contact: Pharmacy POS Help Desk at 877-463-7671 or 515-725-1107 (local) and verify the quantity, days' supply, and dose.

Antialcoholic preparations
Antiarrhythmics
Antidepressant combinations
Antidepressants
Antihistamines
Antimania drugs
Barbiturates
Coagulants
Digitalis glycosides
Heparin and related compounds
Iron replacement
NSAIDs
Oral anticoagulants, Coumarin type
Oral anticoagulants, Inandione type
Oxytocics
Platelet aggregation inhibitors
Thyroid hormones
Vitamin A preparations
Vitamin D preparations
Vitamin E preparations
Vitamin K preparations
Xanthines

Revised 7/1/98

g. Quantity Limits

Medication doses that use multiple, lower-strength tablets should be consolidated to the higher-strength tablet. Quantity limits based on the compendia are also enforced. Prior authorization is required if there is a reason the higher tablet strength cannot be used or medical rationale for use of higher than recommended dosing is required.

Drug product	Quantity	Days supply	Comments
Abilify 2mg	30	30	
Abilify 5mg	30	30	
Abilify 10mg	30	30	
Abilify 15mg	30	30	
Abilify 20mg	30	30	
Abilify 30mg	30	30	
Aceon 2mg	30	30	
Aceon 4mg	30	30	
Aceon 8mg	60	30	
Aciphex 20mg	60	30	
Actonel tab 5mg	30	30	
Actonel tab 30mg	30	30	
Actonel tab 35mg	4	30	

Drug product	Quantity	Days supply	Comments
Actoplus met 15-500mg	60	30	
Actoplus met 15-850mg	60	30	
Actos 15mg	30	30	
Actos 30mg	30	30	
Actos 45mg	30	30	
Adalat cc 30mg (Procardia)	30	30	
Adalat cc 60mg (Procardia)	30	30	
Adalat cc 90mg (Procardia)	30	30	
Advair 100/50 diskus	60	30	
Advair 250/50 diskus	60	30	
Advair 500/50 diskus	60	30	
Advair HFA	1 inhaler (12 gm)	30	
Aerobid	21	30	
Aerobid-m	21	30	
Aldara cream	12 pkts	28	Payable for members aged 12 or older. Max 48 packets/16 weeks
Altace 1.25mg	30	30	
Altace 2.5mg	30	30	
Altace 5mg	30	30	
Altace 10mg	60	30	
Amaryl 1mg	30	30	
Amaryl 2mg	30	30	
Ambien cr cap 6.25mg	15	30	PA required for more than 15 days' sedative hypnotic therapy
Ambien cr cap 12.5mg	15	30	PA required for more than 15 days' sedative hypnotic therapy
Androgel 1%(25mg) gel	30 pkts	30	
Androgel 1%(50mg) gel	60 pkts	30	
Androgel pump	300gm	30	
Aricept ODT tab 5mg	30	30	Restricted to members aged 40 or older.
Aricept ODT tab 10mg	30	30	Restricted to members aged 40 or older.
Aricept tab 5mg	30	30	Restricted to members aged 40 or older.
Aricept tab 10mg	30	30	Restricted to members aged 40 or older.
Astelin nasal spray	30ml	30	
Atacand 4mg	30	30	
Atacand 8mg	30	30	

Drug product	Quantity	Days supply	Comments
Atacand 16mg	30	30	
Atacand 32mg	30	30	
Atacand HCT 16-12.5mg	30	30	
Atacand HCT 32-12.5mg	30	30	
Atrovent HFA	2 bottles (25.8 gm)	30	
Atrovent inhaler	2 inhalers (28 gm)	30	
Avalide 150-12.5mg	30	30	
Avalide 300-12.5mg	30	30	
Avalide 300-25mg	30	30	
Avandaryl 4mg/1mg	60	30	
Avandaryl 4mg/2mg	60	30	
Avandaryl 4mg/4mg	60	30	
Avandia 8mg	30	30	
Avapro 75mg	30	30	
Avapro 150mg	30	30	
Avapro 300mg	30	30	
Avinza 30mg	30	30	
Avinza 60mg	30	30	
Avinza 90mg	30	30	
Avinza 120mg	150	30	
Azmacort	2 inhalers (40 gm)	30	
Beconase aq	2 inhalers (50 gm)	30	
Benicar 5mg	30	30	
Benicar 20mg	30	30	
Benicar 40mg	30	30	
Benicar Hct 20-12.5mg	30	30	
Benicar HCT 40-12.5mg	30	30	
Benicar HCT 40-25mg	30	30	
Bisoprolol 5mg (Zebeta)	30	30	
Boniva 2.5mg	30	30	
Boniva 150mg	1 tablet	30	
Boniva syr	1 syringe	90	
Bupropion ER 150mg (Wellbutrin XL)	30	30	
Bupropion ER 300mg (Wellbutrin XL)	30	30	

Drug product	Quantity	Days supply	Comments
Bupropion HCL 75mg tablet	180	30	
Bupropion HCL 100mg tablet	90	30	
Bupropion SR 100mg tablet	60	30	
Bupropion SR 150mg tablet	60	30	
Bupropion SR 200mg tab	60	30	
Caduet 2.5-20mg	30	30	
Caduet 2.5-40mg	30	30	
Caduet 2.5-100mg	30	30	
Caduet 5-10mg	30	30	
Caduet 5-20mg	30	30	
Caduet 5-40mg	30	30	
Caduet 5-80mg	30	30	
Caduet 10-10mg	30	30	
Caduet 10-20mg	30	30	
Caduet 10-40mg	30	30	
Caduet 10-80mg	30	30	
Carisoprodol 350mg	120	30	
Celebrex 100mg	60	30	
Celebrex 200mg	30	30	
Celebrex 400mg	30	30	
Celexa 10mg	30	30	
Celexa 20mg	45	30	
Combivent 14.7gm inhaler	3 inhalers (44.1 gm)	30	
Combunox (5mg oxycodone/400mg ibuprofen)	28	30	
Concerta SA 18mg	60	30	
Concerta SA 27mg	60	30	
Concerta SA 36mg	60	30	
Concerta SA 54mg	60	30	
Cozaar 25mg	60	30	
Cozaar 50mg	60	30	
Cozaar 100mg	30	30	
Crestor 5mg	30	30	
Crestor 10mg	30	30	
Crestor 20mg	30	30	
Crestor 40mg	30	30	

Drug product	Quantity	Days supply	Comments
Cymbalta 20mg capsule	60	30	
Cymbalta 30mg capsule	90	30	
Cymbalta 60mg capsule	60	30	
Daytrana 10mg/9 hr patch	30	30	
Daytrana 15mg/9 hr patch	30	30	
Daytrana 20mg/9 hr patch	30	30	
Daytrana 30mg/9 hr patch	30	30	
Detrol la 2mg	30	30	
Detrol la 4mg	30	30	
Dextroamphetamine 5mg cap SR	60	30	
Dextroamphetamine 10mg cap SR	60	30	
Dextroamphetamine 15mg cap SR	60	30	
Diastat	6	30	
Diazepam syr (Valium)	15 syringes	30	
Differin 0.1% cream	45	30	
Differin 0.1% gel	45	30	
Diovan 40mg	30	30	
Diovan 80mg	30	30	
Diovan 160mg	30	30	
Diovan 320mg	30	30	
Diovan HCT 80-12.5mg	30	30	
Diovan HCT 160-12.5mg	30	30	
Diovan HCT 160-25mg	30	30	
Diovan HCT 320-12.5mg	30	30	
Diovan HCT 320-25mg	30	30	
Ditropan XL 5mg	30	30	
Doral 7.5mg	30	30	
Doral 15mg	30	30	
Duoneb 3ml vial	620ml	30	
Effexor XR 37.5mg	30	30	
Effexor XR 75mg	30	30	
Effexor XR 150mg	90	30	
Elidel	NA	NA	Restricted to members aged 2 or older
Emsam 6mg/24 hours patch	30	30	
Emsam 9mg/24 hours patch	30	30	

Drug product	Quantity	Days supply	Comments
Emsam 12mg/24 hours patch	30	30	
Enablex 7.5mg	30	30	
Enablex 15mg	30	30	
Epipen	4 units	30	
Epipen, Jr	4 units	30	
Estraderm	8 patches	30	
Exelon 1.5mg capsule	60	30	Restricted to members aged 40 or older.
Exelon 2mg/mL oral solutio	180ml	30	Restricted to members aged 40 or older.
Exelon 3mg capsule	60	30	Restricted to members aged 40 or older.
Exelon 4.5mg capsule	60	30	Restricted to members aged 40 or older.
Exelon 6mg capsule	60	30	Restricted to members aged 40 or older.
Exubera kit	1 kit	365	Restricted to members aged 40 or older.
Fexofenadine 30mg (Allegra)	60	30	
Fexofenadine 60mg (Allegra)	60	30	
Fexofenadine 180mg (Allegra)	30	30	
Flovent HFA 44mcg	1 inhaler (10.6 gm)	30	
Flovent HFA 110mcg	1 inhaler (12 gm)	30	
Flovent HFA 220mcg	2 inhalers (24 gm)	30	
Flunisolide 0.025% spray (Nasarel)	3 bottles (75ml)	30	
Fluoxetine 20mg/5 mL solut	600ml	30	
Fluoxetine HCL 10mg tablet	45	30	
Fluoxetine HCL 10mg capsul	30	30	
Fluoxetine HCL 20mg capsul	120	30	
Fluoxetine HCL 40mg capsul	60	30	
Flurazepam 15mg (Dalmane)	30	30	

Drug product	Quantity	Days supply	Comments
Fluticasone propionate sup 50mcg/act (Flonase)	2 inhalers (32 gm)	30	
Focalin XR 5mg	60	30	
Focalin XR 10mg	60	30	
Focalin XR 15mg	90	30	
Focalin XR 20mg	90	30	
Foradil aerolizer	60	30	
Fosamax 5mg	30	30	
Fosamax 10mg	30	30	
Fosamax 40mg	30	30	
Fosamax 70mg	4	30	
Fosinorpil 10mg (Monopril)	60	30	
Fosinorpil 20mg (Monopril)	60	30	
Fosinorpil 40mg (Monopril)	60	30	
Geodon 20mg capsule	60	30	
Geodon 40mg capsule	60	30	
Geodon 60mg capsule	60	30	
Geodon 80mg capsule	60	30	
Glucagon emergency kit	5	30	
Haldol decanoate 50mg/mL-1ml per vial	1ml	30	
Haldol decanoate 50mg/mL-5ml per vial	10ml	30	
Haldol decanoate 100mg/mL-1ml per vial	1ml	30	
Haldol decanoate 100mg/mL-5ml per vial	5ml	30	
Hyzaar 50-12.5mg	30	30	
Hyzaar 100-25mg	30	30	
Innopran XL 80mg	30	30	
Intal inhaler	3 inhalers (42.6 gm)	30	
Invega 3mg tablet	30	30	
Invega 6mg tablet	60	30	
Invega 9mg tablet	30	30	
Ipatropium 0.03% nasal spray (Atrovent)	2 bottles (60ml)	30	
Ipatropium 0.06% nasal spray (Atrovent)	2 bottles (30ml)	30	
Lefluomide 10mg (Arava)	30	30	
Lefluomide 20mg (Arava)	30	30	
Lefluomide 100mg (Arava)	3	30	
Lescol 20mg	30	30	

Drug product	Quantity	Days supply	Comments
Lexapro 5mg tablet	30	30	
Lexapro 10mg tablet	30	30	
Lexapro 20mg	60	30	
Lipitor 10mg tablet	30	30	
Lipitor 20mg tablet	30	30	
Lipitor 40mg tablet	30	30	
Loratadine 10mg (Alavert, Claritin, Tavist ND)	30	30	
Lovastatin 10mg (Mevacor)	30	30	
Lovastatin 20mg (Mevacor)	30	30	
Lovastatin 40mg (Mevacor)	60	30	
Lunesta tab 1mg	15	30	PA required for more than 15 days' sedative hypnotic therapy
Lunesta tab 2mg	15	30	PA required for more than 15 days' sedative hypnotic therapy
Lunesta tab 3mg	15	30	PA required for more than 15 days' sedative hypnotic therapy
Luvox 25mg	30	30	
Luvox 50mg	30	30	
Lyrica 25mg	90	30	
Lyrica 50mg	90	30	
Lyrica 75mg	90	30	
Lyrica 100mg	90	30	
Lyrica 150mg	90	30	
Lyrica 200mg	90	30	
Lyrica 225mg	60	30	
Lyrica 300mg	60	30	
Mavik 1mg	30	30	
Mavik 2mg	30	30	
Mavik 4mg	60	30	
Maxair autoinhaler 14g	2 inhalers (28 gm)	30	
Meloxican 7.5mg (Mobic)	30	30	
Meloxican 15mg (Mobic)	30	30	
Metadate CD 10mg	60	30	
Metadate CD 20mg	90	30	
Metadate CD 30mg	60	30	
Metadate CD 40mg	60	30	
Metadate CD 50mg	60	30	
Metadate CD 60mg	60	30	

Drug product	Quantity	Days supply	Comments
Metadate ER 10mg tablet	90	30	
Metadate ER 20mg tablet	90	30	
Methylin ER 10mg tablet SA	90	30	
Methylin ER 20mg tablet SA	90	30	
Methylphenidate ER 20mg TA	90	30	
Miacalcin nasal 200 u/dose	4ML	30	
Mirtazapine 15mg (Remeron)	45	30	
Mirtazapine 30mg (Remeron)	30	30	
Mirtazapine 45mg (Remeron)	30	30	
Morphine sulfate SA 15mg	90	30	
Morphine sulfate SA 30mg	90	30	
Morphine sulfate SA 60mg	90	30	
Morphine sulfate SA 100mg	300	30	
Namenda 2mg/1ml oral solution	300ml	30	Comes in 360ml containers. Restricted to members aged 40 or older
Namenda 5mg	60	30	Restricted to members aged 40 or older.
Namenda 10mg	60	30	Restricted to members aged 40 or older.
Nasacort aq	2 bottles (33 gm)	30	
Nasonex 50mcg nasal spray	2 bottles (34 gm)	30	
Nexium 20mg	30	30	
Nexium 40mg	60	30	
Norvasc 2.5mg	30	30	
Norvasc 5mg	30	30	
Omeprazole 10mg (Prilosec RX)	30	30	
Omeprazole 20mg (Prilosec RX)	30	30	
Paroxetine 10mg (Paxil)	30	30	
Paroxetine 20mg (Paxil)	30	30	
Paroxetine 30mg (Paxil)	30	30	
Paroxetine 40mg (Paxil)	45	30	
Paxil cr 12.5mg	30	30	

Drug product	Quantity	Days supply	Comments
Paxil cr 25mg	60	30	
Paxil cr 37.5mg	60	30	
Pravastatin tab 10mg (Pravachol)	30	30	
Pravastatin tab 20mg (Pravachol)	30	30	
Pravastatin tab 40mg (Pravachol)	30	30	
Pravastatin tab 80mg (Pravachol)	30	30	
Premarin 0.625mg	30	30	
Premarin vaginal cream	1 tube (42.5 gm)	30	
Prevacid cap 15mg	30	30	PA required for PPI therapy over 60 days
Prevacid cap 30mg	60	30	PA required for PPI therapy over 60 days
Prevacid granules 15mg	30	30	PA required for PPI therapy over 60 days
Prevacid granules 30mg	60	30	PA required for PPI therapy over 60 days
Prevacid solutabs 15mg	30	30	PA required for PPI therapy over 60 days
Prevacid solutabs 30mg	60	30	PA required for PPI therapy over 60 days
Prilosec 20mg OTC	120	30	PA required for PPI therapy over 60 days
Prilosec 40mg RX	60	30	
Proair HFA 8.5gm	3 inhalers (25.5 gm)	30	
Protonix 20mg	30	30	PA required for PPI therapy over 60 days
Protonix 40mg	60	30	PA required for PPI therapy over 60 days
Protopic ointment	120	30	0.03% ointment is payable only for members aged 2 or older. 0.1% ointment is payable only for members aged older
Provigil 100mg	30	30	PA required for members aged 16 or older.
Provigil 200mg	60	30	PA required for members aged 16 or older.

Drug product	Quantity	Days supply	Comments
Pulmicort flexhaler 180mcg/dose	2	30	
Pulmicort turbuhaler	2	30	
Qvar 40mcg	3 inhalers (21.9 gm)	30	
Qvar 80mcg	3 inhalers (21.9 gm)	30	
Razadyne (all strengths)	NA	30	Restricted to members aged 40 or older.
Rhinocort aqua sus	8.6 grams	30	
Risperdal 0.25mg	120	30	
Risperdal 0.5mg	120	30	
Risperdal 0.5mg m-tab	120	30	
Risperdal 1mg	120	30	
Risperdal 1mg m-tab	120	30	
Risperdal 2mg	90	30	
Risperdal 2mg m-tab	90	30	
Risperdal 3mg	60	30	
Risperdal 3mg m-tab	60	30	
Risperdal 4mg	60	30	
Risperdal 4mg m-tab	60	30	
Risperdal consta 25mg syr	2 syringes	28	
Risperdal consta 37.5mg sy	2 syringes	28	
Risperdal consta 50mg syr	2 syringes	28	
Ritalin la 10mg capsule	30	30	
Ritalin la 20mg capsule	30	30	
Ritalin la 30mg capsule	60	30	
Ritalin la 40mg capsule	30	30	
Rozerem tab 8mg	15	30	
Serevent diskus 60 blisters	1 package (60)	30	
Sonata cap 5mg	15	30	
Sonata cap 10mg	15	30	
Spiriva cap handihaler pkg size 30	30	30	
Strattera 10mg capsule	60	30	
Strattera 18mg capsule	60	30	
Strattera 25mg capsule	60	30	
Strattera 40mg capsule	60	30	
Strattera 60mg capsule	30	30	
Strattera 80mg capsule	30	30	
Strattera 100mg capsule	30	30	

Drug product	Quantity	Days supply	Comments
Terazosin 1mg (Hytrin)	30	30	
Terazosin 2mg (Hytrin)	60	30	
Terazosin 5mg (Hytrin)	30	30	
Terazosin 10mg (Hytrin)	60	30	
Tilade inhaler	3 inhalers (48.6 gm)	30	
Toprol XL 25mg	45	30	
Toprol XL 50mg	45	30	
Toprol XL 100mg	45	30	
Toprol XL 200mg	60	30	
Tramadol 50mg	240	30	
Tramadol/acetaminophen 325mg/37.5mg	240	30	
Tricor 48mg	30	30	
Tricor 145mg	30	30	
Triglide 160mg	30	30	
Ultram ER 100mg	30	30	
Ultram ER 200mg	30	30	
Ultram ER 300mg	30	30	
Uroxatrol	30	30	
Vivelle/Vivelle-Dot	8 patches	28	
Xanax XR 0.5mg	30	30	
Xanax XR 1mg	30	30	
Xolair sol 150mg	6	30	
Zegerid cap 20mg	30	30	
Zegerid cap 40mg	60	30	
Zegerid powder for oral susp 20mg	30	30	
Zegerid powder for oral susp 40mg	60	30	
Zetia 10mg	30	30	
Zocor 5mg	30	30	
Zocor 10mg	30	30	
Zocor 20mg	30	30	
Zocor 40mg	30	30	
Zyprexa 2.5mg tablet	30	30	
Zyprexa 5mg tablet	30	30	
Zyprexa 7.5mg tablet	30	30	
Zyprexa 10mg tablet	30	30	
Zyprexa 15mg tablet	60	30	
Zyprexa 20mg tablet	60	30	
Zyprexa Zydis 5mg tablet	30	30	

Drug product	Quantity	Days supply	Comments
Zyprexa Zydis 10mg tablet	30	30	
Zyprexa Zydis 15mg tab	60	30	
Zyprexa Zydis 20mg tablet	60	30	
Zyrtec 5mg	30	30	
Zyrtec 10mg	30	30	
Zyrtec-D 5-120mg	60	30	

h. Refill Too Soon

If less than 75% of the previously paid claim (85% for controlled substances, carisoprodol and tramadol-containing products) for that medication has not been used. If there is a change in dose; lost, stolen or destroyed drug; or travel an override will be considered.

i. Therapeutic Duplication

If a second claim submitted is a therapeutic duplication of a drug already submitted and reimbursed, overlapping claims will be considered on an individual basis.

Deny regardless of prescriber	
Antiulcer preparations	Provide prescriber verified documentation of the necessity of the duplication in the treatment plan.
Andrenergic agents, aromatic, non-catecholamine	Provide prescriber verified documentation of the necessity of the duplication in the treatment plan.
Anti-narcolepsy/anti-hyperkinesis agents	Provide prescriber verified documentation of the necessity of the duplication in the treatment plan.
Barbiturates	Provide prescriber verified documentation of the necessity of the duplication in the treatment plan.
Central nervous system stimulants	Provide prescriber verified documentation of the necessity of the duplication in the treatment plan.
Digitalis glycosides	Provide prescriber verified documentation of the necessity of the duplication in the treatment plan.

2. Common Billing Errors

Medications can often be described using three measures: each, grams, and milliliters. It is important to choose the correct unit of measure when billing.

Medication	Correct Unit of Measure for Billing	Quantity	Days Supply
Byetta 5mcg	mL (Submit in decimal format; do not round)	1.2mL	30
Byetta 10mcg	mL (Submit in decimal format; do not round)	2.4mL	30
Copaxone	Each	1	30
Diastat ACDL Gel	Each (Kit contains 2 syringes bill # of kits)	1	Varies
Elaprase 6mg/3ml	mL	Varies should be divisible by 3ml	30
Enbrel 25mg	Each	1	1
Enbrel 25mg/0.5ml	mL (Submit in decimal form; do not round)	Varies claims should be divisible by 0.5mL	30
Enbrel SureClick	mL (Submit in decimal format; do not round)	Varies should be divisible by .98mL	30
Fragmin	mL (Submit in decimal format; do not round)	Varies	Varies
Gamunex 10%	mL (Each vial is 10ml)	Varies	Varies
Humira	Each (Kit contains 2 syringes)	2	30
Influenza Vaccines	mL (Submit in decimal format; do not round)	0.5mL	1
Kineret	mL (Submit in decimal format; do not round)	Varies should be divisible by 0.67	30
Lovenox	mL (Submit in decimal format; do not round)	Varies	Varies
Miacalcin NS	mL (Submit in decimal format; do not round)	3.7	30
Nascobal	mL (Submit in decimal format; do not round)	Varies; claims should be divisible by 2.3mL	30
Neupogen 400mcg	mL (Submit in decimal format; do not round)	Varies; claims should be divisible by 1.6mL	30
Neupogen 600mcg	mL (Submit in decimal format; do not round)	Varies; claims should be divisible by 0.5mL	30
Pegasys	Each (Kit contains 4 syringes)	1	28
Orencia	Each	1	Varies
Peranex HC	Each	1	Varies
Proair HFA	Grams	8.5 grams	30

Medication	Correct Unit of Measure for Billing	Quantity	Days Supply
Proventil HFA	Grams	6.7 grams	30
Rebif pack	mL (Submit in decimal format; do not round)	4.2 mL	30
Rebif syringe	mL (Submit in decimal format; do not round)	6 mL	30
Remicade	Each	1	Varies
Restasis	Each	32/64	30
Risperdal Consta	Each	2	28
Stadol nasal spray 10mg/mL	mL (Submit in decimal format; do not round)	Varies; Claims should be divisible by 2.5mL	Varies
Synagis 50mg	mL (Submit in decimal format; do not round	0.5mL	30
Synagis 100mg	mL	1mL	30
Ventolin HFA	Grams	18 grams	30
Xopenex HFA	Grams	Varies; claims should be divisible by 15grams	Varies

3. Compounded Prescriptions

Iowa Medicaid will process claims for compounded prescriptions in the NCPDP 5.1 format using the multiple ingredient functionality. All applicable edits, including Preferred Drug List (PDL) rules, apply to each NDC submitted. Providers must submit the NDCs for the active ingredients dispensed to create the compound.

A dispensing fee will be added to the claim when a drugs within the compound is reimbursed at EAC or State MAC price. There will be no additional fee paid to prepare the compounded prescription. Providers need to submit the quantity of the active ingredients used in the compound for reimbursement, not the quantity of the total amount of the compound made.

H. REMITTANCE ADVICE AND FIELD DESCRIPTIONS

1. Remittance Advice Explanation

To simplify your accounts receivable reconciliation and posting functions, you will receive a comprehensive *Remittance Advice* with each Medicaid payment. The *Remittance Advice* is also available on magnetic computer tape for automated account receivable posting.

The *Remittance Advice* is separated into categories indicating the status of those claims listed below. Categories of the *Remittance Advice* include paid, denied, and suspended claims.

- **Paid** indicates all processed claims, credits and adjustments for which there is full or partial reimbursement.
- **Denied** represents all processed claims for which no reimbursement is made.
- **Suspended** reflects claims that are currently in process pending resolution of one or more issues (member eligibility determination, reduction of charges, third party benefit determination, etc.).

Suspended claims may or may not print depending on which option was specified on the Medicaid Provider Application at the time of enrollment. You chose one of the following:

- Print suspended claims only once.
- Print all suspended claims until paid or denied.
- Do not print suspended claims.

Note that claim credits or recoupments (reversed) appear as regular claims with the exception that the transaction control number contains a "1" in the twelfth position and reimbursement appears as a negative amount.

An adjustment to a previously paid claim produces two transactions on the *Remittance Advice*. The first appears as a credit to negate the claim; the second is the replacement or adjusted claim, containing a "2" in the twelfth position of the transaction control number.

If the total of the credit amounts exceeds that of reimbursement made, the resulting difference (amount of credit – the amount of reimbursement) is carried forward and no check is issued. Subsequent reimbursement will be applied to the credit balance, as well, until the credit balance is exhausted.

A detailed field-by-field description of each informational line follows. It is important to study these examples to gain a thorough understanding of each element as each *Remittance Advice* contains important information about claims and expected reimbursement.

Regardless of one's understanding of the *Remittance Advice*, it is sometimes necessary to contact IME Provider Services with questions. When doing so, keep the *Remittance Advice* handy and refer to the transaction control number of the particular claim. This will result in timely, accurate information about the claim in question.

2. Remittance Advice Sample and Field Descriptions

To view a sample of this form on line, click here.

NUMBER	DESCRIPTION
1.	Pay-to provider's name as specified on the Medicaid Provider Enrollment Application.
2.	*Remittance Advice* number.
3.	Date claim paid.
4.	Medicaid (Title XIX) pay-to provider's number.
5.	Member's last and first name.
6.	Member's Medicaid identification number.
7.	Transaction control number assigned by IME to each claim. Please use this number when making inquiries about claims.
8.	Date drug dispensed.
9.	National drug code.
10.	Sub units of service from claims.
11.	Prescription number as assigned by provider.
12.	Total charges submitted by provider.
13.	Total amount applied to this claim from other resources, i.e., other insurance or spenddown.
14.	Total amount paid by Medicaid for this claim.

NUMBER	DESCRIPTION
15.	Total amount of member copayment deducted from this claim.
16.	Allowed charge source code. **E** EAC price + dispensing fee **G** FMAC price + dispensing fee **B** Billed charge
17.	Explanation of benefits code indicates the reason for claim denial. Refer to the explanation at the end of the remittance for each EOB code in the *Remittance Advice*.
18.	Name of prescribing provider.
19.	Drug name and description.
20.	Number of paid original claims, amount billed, and amount allowed and paid. • Number of paid adjusted claims, amount billed, and amount allowed and paid. • Number of denied original claims and amount billed. • Number of denied adjusted claims, amount billed, and amount allowed and paid. • Number of pended claims (in process), amount billed, and amount allowed. • Amount of check.